

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

BUILDING ON PROGRESS:
Achieving parity for mental
health in Northern Ireland

FINAL REPORT

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Building on progress: Achieving parity for mental health in Northern Ireland

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The independent Commission on Acute Adult Psychiatric Care was set up by the Royal College of Psychiatrists in January 2015 in response to widespread concerns about the provision of acute inpatient psychiatric beds in many parts of England and Northern Ireland. It is chaired by Lord Nigel Crisp, former Chief Executive of the NHS in England and former Permanent Secretary of the Department of Health, with support from 14 Commissioners with a diverse range of expertise in mental health and related sectors. More information is available on the Commission's website: www.caapc.info

This report sets out the findings of the Commission on Acute Adult Psychiatric Care's work in Northern Ireland.

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The Commission's work has been funded and supported by the Royal College of Psychiatrists from its own resources. However, the Commission and its work remain wholly independent of the College.

The Chair, commissioners and members of the Advisory Groups have not received any payment for their contributions to the Commission's work, although session fees have been paid to patient and carer representatives on the Commission and the Commission Advisory groups. These payments were made in line with the College's policy for patient and carer engagement.

Commissioners all have, or have had, some engagement in mental health or related fields (see Appendix 1). Any relevant interests are listed in the brief biographies on the Commission's website (www.caapc.info).

The Commission is extremely grateful to everyone who supported the Commission during its work. For a full list of acknowledgments, please see Appendix 2.

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Foreword

Mental health needs to be given the same priority as physical health. Put simply – someone in the grip of a severe mental illness needs as much help as someone suffering from a stroke or heart attack.

We would go further and argue that improving mental health is an essential part of all policies to improve the social and economic well-being of the Region. We believe that the new Assembly in Northern Ireland has a tremendous opportunity to make sure this happens.

Our focus as a Commission has been on adult acute inpatient care – and particularly the problems in admitting patients which have been getting worse in recent months. We have, however, had to look at the whole mental health system because every part of the system affects every other and the difficulties in acute admissions are directly related to shortages of community services, specialist community and inpatient services and supported housing. Our recommendations therefore address how to make the whole system work better.

We have been constantly impressed by the people we have met and many of the services we have seen. There is much to be proud of and in our view the level of engagement of patients and carers in the mental health system in Northern Ireland is better than elsewhere in the UK.

The Commissioners have very much appreciated all the advice and help we have received from so many people in Northern Ireland and the efforts people have made to make sure that we – mostly coming from England – understand enough of the culture and circumstances to make recommendations that make sense in the local context.

We are very grateful for the support of the Royal College of Psychiatrists and particularly want to thank Greg Smith, Krista Nicholson and Lucy Thorpe for their tremendous work as well as their colleagues in Northern Ireland who have hosted our visits.

Lord Nigel Crisp

On behalf of the Commissioners

Key points

Mental health in Northern Ireland must be given equal priority with physical health. This is particularly important because of the large numbers of people with mental health problems and the high levels of suicide.

Northern Ireland spends less than other parts of the UK on mental health – and severely mentally ill patients can't be certain that they will receive the same rapid access to good quality care and treatment as they would get if they were severely physically ill.

There have been big improvements in recent years and the Commission found many good services. It was very impressed, in particular, by the engagement of patients and carers. The Commission's survey of acute wards, however, revealed a system that is under strain and not functioning efficiently. There are problems in admitting patients; about 1 in 4 inpatients could be better treated in a different setting; and 1 in 5 are ready for discharge.

There are a number of system wide issues which contribute to these problems:

- Too few community and specialist services
- A shortage of supported housing
- Weak commissioning arrangements
- Organisational boundaries that get in the way of improving quality and efficiency
- As elsewhere in the UK, there is poor data available on which to base decisions
- Mental health funding is proportionately less than in other parts of the UK

The Commission was struck by how consistent its findings were with the many recent reviews of mental health and wider health and care services

including the Bamford Review and its subsequent implementation plans; the Donaldson Report; and the Transforming Your Care process and strategy. It also noted that there was growing awareness amongst policy makers and politicians that improved mental health must be a central element in every strategy for improving life in Northern Ireland from health and education to employment and economic policy.

The Commission understands that health and social care in Northern Ireland is facing enormous financial pressures – as elsewhere in the UK – and that difficult decisions will need to be made. It believes, however, that there is a need for investment in mental health, with some re-balancing with physical health, but that many improvements can be made without cost and many investments will save money in the longer term.

There is a clear direction and a coherent framework of mental health and related policy. At the same time, there is enormous energy, commitment and initiative amongst people working in mental health whether as peer support workers, advocates, carers, health and care workers or volunteers.

Taken together, these strong foundations provide the new Assembly with an excellent opportunity to give mental health equal priority with physical health, to make it fully part of wider social and economic strategies and to focus on making changes for the benefit of mental health patients, their carers and families and the wider community.

Recommendations

The Commission's recommendations build on the current strategy and are designed to help people engaged in the sector realise their aims and ambitions.

1. Parity of esteem

Mental health needs to be explicitly given equal priority with physical health by both the Department of Health and the Assembly. This would mean that mental health patients have the same levels of access and standards as for physical health, a four hour maximum wait target between the decision to treat and admission or acceptance by a CRHT should be introduced alongside a 24hr Home Treatment Team availability standard, data on performance should be published, funding must be protected, and there needs to be clear unified leadership across the whole service.

2. A single mental health service for Northern Ireland

The Department of Health, the Public Health Agency and the five Health and Social Care Trusts need to find ways to create a single service across Northern Ireland with less fragmentation of services, the adoption of common systems and standards and the development of a managed care network to enable more effective cross-boundary working and improve quality and efficiency.

3. Improved functioning of the whole system

Planners and providers need to work together across the Region to undertake a service capacity assessment and improvement review to ensure there are effective systems and sufficient capacity in different types of services (potentially including new specialist services) to enable patients to be cared for in the most appropriate setting.

4. Quality improvement and standards for acute adult wards

The current work to develop the capacity and capability for quality improvement throughout the whole system needs to be strengthened – to ensure everyone is working with a common approach and methodology – and linked with the development of a single set of easy to understand and measurable quality standards for acute adult psychiatric wards.

5. Support for patients and carers

The current programmes for engaging and supporting patients and carers should be continued with greater emphasis given to the early involvement of carers wherever possible and appropriate.

This will involve providers working with commissioners, patients and carers to evaluate current patient and carer involvement in service planning and delivery, and improve it as necessary; evaluating promising schemes such as peer support and advocacy services and peer-led services, in order to demonstrate their efficacy, identifying how they can be improved and share good practice; ensuring that patients and carers involved in service planning or delivery functions receive the training, development and support they need to do so; assessing whether current policies re the involvement of police in assessments/admission are appropriate and implementing and monitoring the Triangle of Care.

6. Investment for better value and improved quality

There needs to be further investment in community services and new investment in specialist services and supported housing. Some of this can be achieved through an Invest to Save Programme which could be designed to reduce waste in the system and improve the efficiency of the whole service.

7. Commissioning

The current system of commissioning services needs to be replaced by a simpler and more rigorous evidence-based approach and better financial mechanisms.

8. Improved data

The collection, quality and use of clinical, financial, patient and carer experience and organisational data needs to be radically improved – with the introduction of a minimum data set – so they can be used to improve services and efficiency, ensure evidence-based care is delivered and improve accountability.

Glossary of terms

Terms

Acute psychiatric care

Acute psychiatric care is the treatment and support provided to people who are either experiencing, at risk of, or recovering from a mental health crisis. This could include inpatient care on acute psychiatric wards, care in the community by a CRHT, care in acute day services or in crisis/recovery houses.

Acute psychiatric wards

Acute psychiatric wards provide inpatient care to people when their illness cannot be managed in the community.

Bamford Review

The Bamford Review was commissioned in 2002 by the DHSSPS and reviewed the law, policies and provision of services relevant to both mental illness and learning disability. It concluded its work in 2007 but, alongside Transforming Your Care, has remained the main framework for continuing improvements in mental health and learning disability services in Northern Ireland.

Community Mental Health Teams (CMHT) and Primary Care and Recovery Teams (PCRT)

CMHTs and PCRTs are secondary mental health services which provide support to people living in the community who have complex or serious mental health problems.

Crisis House

Crisis houses are community-based crisis services that offer residential support to people experiencing a mental health crisis. There are various models of crisis house and they can be clinical or non-clinical in nature.

Crisis Resolution and Home Treatment Team (CRHT)

CRHTs provide intensive support in the community to people experiencing a mental health crisis as an alternative to inpatient care.

Donaldson Review

The Donaldson Review, published in 2014, was commissioned by former Health Minister Edwin Poots and chaired by Professor Sir Liam Donaldson. It examined the arrangements for assuring and improving the quality and safety of care in Northern Ireland.

Extra Contractual Referrals (ECRs)

ECRs occur when patients from Northern Ireland are transferred abroad for care as they require treatment or services not available in the region.

Mental Health (Northern Ireland) Order 1986

The Mental Health (Northern Ireland) Order 1986 is the legislation governing the care, treatment and protection of persons with a mental disorder in Northern Ireland. Significant changes to the legislation were proposed by the Bamford Review and draft legislation – The Mental Capacity Bill – has been published to this effect.

Parity of Esteem

Parity of Esteem means giving mental health equal priority to physical health, so that people with mental health problems will have equal access to care and treatment; the same levels of dignity and respect from health and social care staff; and receive the same quality of physical healthcare as those without a mental health problem.

Rehabilitation Psychiatry Services

Rehabilitation Psychiatry services aim to promote recovery for people with severe and complex mental health problems by minimising symptoms and promoting social inclusion, in order to support patients to live as independently as possible.

Releasing Time to Care/Productive Ward

The Releasing Time to Care /The Productive Ward approach was introduced in Northern Ireland in September 2009 in a joint Public Health Agency (PHA)/ Health and Social Care Board (HSCB) initiative. It aims to improve ward processes and environments to help nurses and therapists spend more time on patient care.

Supported Housing

Supported housing combines housing with support services. Its purpose is to support people with complex mental health problems to live as independently as possible.

Transforming Your Care

Transforming Your Care was the programme of work for reforming health and social care in Northern Ireland, including increasing the amount of care carried out in the community, encouraging early intervention and increasing the personalisation of care.

Quality 2020

Quality 2020 is the 10 year strategy to protect and improve quality in health and social care in Northern Ireland.

Organisations and Groups

Department of Health (formerly the Department of Health, Social Services and Public Safety, DHSSPS)

The Department of Health (formerly the Department of Health, Social Services and Public Safety) is the devolved government department in the Northern Ireland Executive with responsibility for improving health and social wellbeing.

Health and Social Care Trusts

Health and Social Care Trusts provide health and social care services in Northern Ireland, including mental health services.

Health and Social Care Board

The Health and Social Care Board currently commissions health and social care services in Northern Ireland and works with Trusts to ensure that services meet population needs. Its role is currently under review.

Patient and Client Council

The Patient and Client Council represents the public's views and interests in health and social care, reviews the work of health and social care services, and provides public information.

National Institute for Health and Care Excellence (NICE)

NICE publishes evidence-based national guidance and quality standards for health and social care in order to improve outcomes for people using the NHS and other public health and social care services.

Public Health Agency (PHA)

The Public Health Agency oversees health and social well-being improvement, health protection, public health support to commissioning and policy development, research and development.

Royal College of Psychiatrists (RCPsych)

The RCPsych is the professional medical body responsible for supporting psychiatrists throughout their careers, and in setting and raising standards of psychiatry in the United Kingdom.

Regulation and Quality Improvement Authority (RQIA)

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. It has the responsibility for monitoring, inspecting and encouraging improvements in the quality of health and social care services

01

Overview

Summary

This chapter sets out the Commission's purpose and approach.

It goes on to give an overview of mental health in Northern Ireland and to describe the wider policy, political and organisational context.

This means that mental health patients should have the same levels of access and standards as for physical health, a four hour maximum wait target between the decision to treat and admission or acceptance by a CRHT should be introduced alongside a 24hr Home Treatment Team availability standard, data on performance should be published, funding must be protected, and there needs to be clear unified leadership across the whole service.

The chapter also makes recommendations about the future arrangements for commissioning and about how to reduce fragmentation of services and create a single mental health service – or managed care network – for the people of Northern Ireland.

The Commission's purpose and approach

The independent Commission was set up by the Royal College of Psychiatrists to address problems in accessing acute inpatient care for adults in both Northern Ireland and England and recommend ways of improving the service.ⁱ

Its terms of reference were to:

- Describe the purpose and value of inpatient services as part of the wider system.
- Propose how to identify the size and scope of safe and therapeutic inpatient services.
- Make recommendations for improvements and propose an implementation plan.

The Commission's brief was to address the problems of access to acute adult inpatient services – with admissions having become much more difficult over recent months. It did, however, recognise from the start that it needed to think in terms of systems and about the whole system of health and social care. Acute adult inpatient services cannot be treated in isolation from everything else – and making changes in any one part of the system will affect everything else. In particular, admissions need to be addressed together with Crisis Resolution and Home Treatment teams (CRHTs) as two elements of the same adult acute service.

The Commission approached its task in a consultative and inclusive way. It established three advisory groups with representatives from both Northern Ireland and England, created working groups to look at particular areas, called for evidence, visited services and met many people from different backgrounds.ⁱⁱ

Members of the Commission understand very well that there have been many reviews, reports and recommendations about health in general and mental health in particular in recent years – and that many people working in the field are weary of investigations, initiatives and advice. They have therefore tried not to duplicate effort, and have tried to quote the findings of earlier reports and their recommendations wherever appropriate. The Commission also notes that an expert panel is currently considering the best model for health and care services in Northern Ireland and has shaped its recommendations accordingly. The Commission's relatively few recommendations build on existing processes and good practice and complement the work of the other commissions and reviewers.

The report concentrates on solutions rather than just problems and contains examples of good practice. The Commission has met many people and organisations working to deliver high quality treatment and care – and been inspired by their commitment, creativity and success – but has also seen large variations in practice and performance. The Commission's conclusions and recommendations are designed both to address the problems and to promote innovation and the sharing of ideas and learning across the whole system.

The Commission's report on England was published in February 2016. This report on Northern Ireland is being published in June so that it is available as soon as possible to newly elected Members of the Assembly.

There is a great deal of similarity between the issues in Northern Ireland and England. In particular health and care services in both countries are under pressure and the financial outlook is very difficult. There are, however, significant differences between the two as described below.

ⁱ See Appendix One for the terms of reference, membership of the Commission and its methodology

ⁱⁱ For a full list of acknowledgements, please see Appendix Two

Mental health in Northern Ireland

There is a high prevalence of mental health problems in Northern Ireland, which is partly associated with the legacy of the Troubles and with relatively high levels of social deprivation in the Region. In summary:

- According to the latest Northern Ireland Health Survey around one in five adults in Northern Ireland shows signs of a mental illness¹
- Northern Ireland had the second highest rates of mental ill-health when matched to 17 other European countries² and the prevalence of mental illness in Northern Ireland is estimated to be more than 20%-25% higher than in England³
- The suicide rate in Northern Ireland is significantly higher than elsewhere in the UK with an estimated 18.6 deaths by suicide per 100,000 population in 2013 compared to 10.1 deaths per 100,000 population in England, 13.0 per 100,000 in Wales and 16.8 per 100,000 in Scotland⁴

Funding for mental health services appears to be lower as a proportion of health and care expenditure than in other parts of the UK. Moreover, when the Region's high levels of social need and deprivation are taken into account analysis from 2010 shows that the Region spent less than half of England's per capita spend on supporting people with mental health problems and learning disabilities.⁵ This is explored in more detail in Chapter Five.

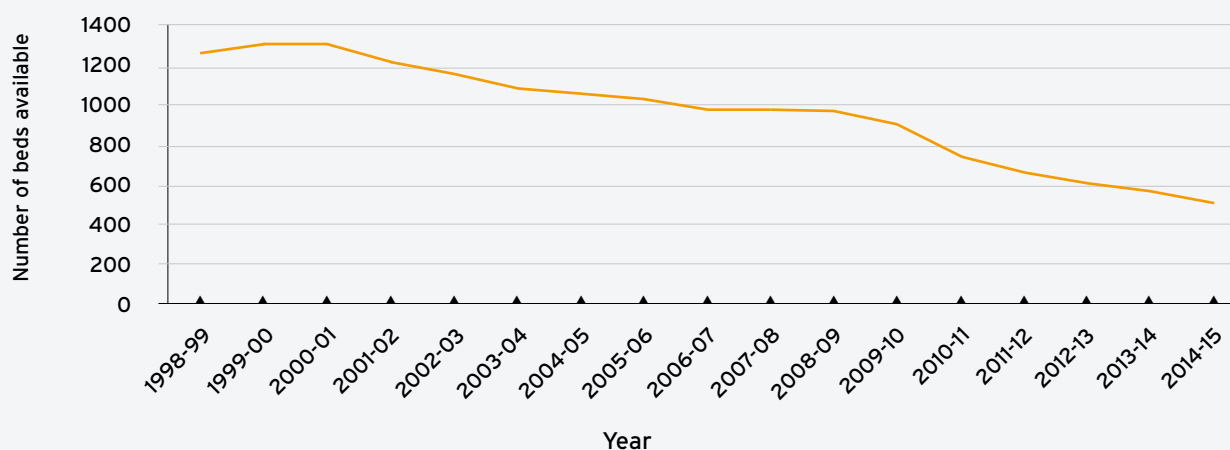
Alongside this higher level of need and lower funding, there are also significant problems in service provision. In particular, patients who require acute or specialist care for their mental health problems cannot be assured that they will have swift access to care when it is needed or that – whether admitted to hospital or looked after by a CRHT – the quality of the care will be of the high standard that they should expect.

These system-wide problems affecting how acute care is delivered are described in later chapters and summarised here in Box 1.1.

Box 1.1: System-wide problems in provision of adult mental health services

- Inadequate availability of acute inpatient care, specialist inpatient care and community-based alternatives to acute and/or specialist inpatient admission when needed.
- Many patients remain in inpatient beds for longer than is necessary in significant part because of inadequate residential provision out of hospital.
- Variable quality of care in inpatient units, reflecting the environment, the interventions available and the number and skills of health and care workers.
- Variation in terms of access to evidence-based therapies across the entire acute care pathway.
- Poor provision of psychological and other specialist services.
- A lack of clarity as to the quality outcomes expected and how these should be reported in a transparent way.
- Variable involvement of patients and their carers in both care received and in the organisation of services.
- A fragmented and relatively weak approach to the commissioning of services.

Figure 1.1: Number of beds available in the Mental Illness Specialty across Northern Ireland between 1998/99 and 2014/15



Note: These figures are for beds in the Mental Illness Specialty only, and do not include Old Age Psychiatry beds.

Data source: Hospital Information Branch (DHSSPSNI) – Annual Hospital Statistics: Mental Health and Learning Disability.

The historical context is that, as Figure 1.1 shows, adult mental health bed numbers have decreased as more care has been transferred to the community. Bed numbers fell by 59% between 1998/99 and 2014/15 and have fallen by 31% since 2010/11.⁶ Admissions to adult mental health beds have also decreased by 52% since 1998/99 and have fallen by 20% in the last five years.⁷

This reduction in bed numbers reflects the deinstitutionalisation process in Northern Ireland and the long-term policy goal for the majority of mental healthcare to be provided in community settings. It depends for its success on good alternative care being available and in particular on the effective functioning of CRHT teams. Several witnesses suggested to the Commission that a limit had been reached in the reduction in bed numbers; others, however, argued that there was scope for further reductions provided good quality alternative care was available. The next chapter discusses the purpose and value of inpatient care within the whole system and considers these issues of capacity and quality.

Mental health services are immensely important for the whole health and well-being of a country. In 2014/15 4,875 people in Northern Ireland were admitted to hospital due to mental illness⁸ – and their families, friends and many others

were affected by their illness. Excluding care for older adults, Northern Ireland spent 8% of its health budget on mental health in 2014/15.⁹ As of 2013/14 Trust expenditure on mental health was £233.78 million¹⁰ of which around 46% was spent on care in hospital settings.¹¹ The indirect cost of mental illness, including time lost from work or education, is very much higher – with one analysis from 2002/3 estimating that the overall cost of mental health problems in Northern Ireland (including human costs and output losses) was £2.85 billion (equivalent to 11.7% of Northern Ireland's GDP in that year.¹² It is essential both for patients and the economy that mental health services are of high quality and that the whole mental health system operates effectively.

Sadly, the problems of access to acute care described here are not new. The Bamford Review, discussed below, described them in very similar fashion and, while there have been improvements since, problems with accessing both inpatient and community services remain. These problems are not universal across the Region and affect different areas in different ways and to differing extent. They are, however, very widespread and damage patient and public perceptions of the service as a whole. They also place great pressures on staff and affect morale and recruitment.

The impacts on patients, carers and staff

The problems described here have an obvious impact on patients, carers and staff. Some patients and carers were very critical of the service and its shortcomings.

One patient told the Commission that: *"I was not listened to and I was not informed about all the aspects of my care. I was discharged with barely any follow up... I have a 'care plan' that I have never actually seen... The professionals consider it as a good care package, however I have no support in crisis".*

Different carers told us that *"inpatient and crisis services in my experience are fundamentally broken... The overall mental health service is piecemeal and fragmented"* and that *"at present there are really no alternatives to the good inpatient care... I allowed my son to literally deteriorate because I could not obtain help in the community. He was eventually sectioned and admitted".*

The Commission also heard from two carers about patients who had either killed themselves or committed homicide after being released from inpatient care.

Clinicians also reported problems with the way the service operates. The Commission was told of *"inappropriate"* use of acute inpatient beds for patients with personality disorders and substance misuse problems. Other health workers reported instances of patients being moved at short notice from ward to ward in order to accommodate new admissions and described poor continuity of care between inpatient and community teams.

These reports should not, however, make us lose sight of the fact that good care is provided for many patients, with around 90% of patients and carers who responded to the 2014 National Audit of Schizophrenia reporting that they were satisfied with the care they had received in the past 12 months.¹³ Box 1.2 contains an example of good quality care being provided in an acute ward. Examples like this show what could be done everywhere by well-motivated staff working in a supportive environment.

Box 1.2: An example of good quality care on an inpatient ward

Southern Health and Social Care Trust

The Trust developed its Inreach Project in response to identified delays in getting patients from acute psychiatric beds discharged to Home Treatment Teams as early as possible.

The Inreach Practitioner ensures there is a seamless journey from community care (if the patient is known to the CRHT) through the inpatient setting and back out to the community. They provide a single point of contact between the Trust's three CRHTs, inpatient services and other statutory and non-statutory services.

The Inreach Practitioner is a member of the CRHT based on the acute wards, working 9-5 Monday to Friday. They attend all multidisciplinary team rounds and discharge planning meetings, raising the profile of the CRHT (and what care they can safely provide in the community), encouraging consideration of home-based care at a much earlier stage in the patient's care pathway and addressing barriers to discharge.

The Inreach Practitioner has a key role in explaining the care pathway to carers and patients. The development of this relationship means that patients and carers are more aware of and comfortable with what the CRHT can provide to care for the patient at home, facilitating patient and carer choice.

Since the introduction of the Inreach Practitioner the average length of stay has reduced, use of 'estimated date of discharge' measures has increased, out-of-area admissions to other Trusts have reduced, clinical management of risk has improved and feedback from patients and carers has been positive.

Mental health policy

Mental health has been given significant attention since the devolution of responsibility for health to the Northern Ireland Assembly in 1999. The Bamford Review and all the activity that has flowed from it has provided a clear and coherent set of actions and policies which have been sustained for more than ten years.

The Bamford Review was commissioned in 2002 and concluded its work in 2007. It had a broad remit to examine the law, policies and 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.¹⁴

However, it also noted that there were "...shortcomings in service provision..."¹⁵ Particular issues identified were the poor availability of community alternatives to admission (for both assessment and crisis care), poor provision of out-of-hours services and the low availability of psychological therapies.

The Strategic Framework also 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 [the] 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."¹⁶

The Review set out a clear direction of travel envisaging "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"¹⁷ "...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"¹⁸ "... the requirement for acute inpatient provision should reduce to approximately 20 places per 100,000." ¹⁹

The Framework stressed that "mental health and social care should be provided in the community unless there is good reason for not doing so."²⁰ It proposed increasing the availability of CHRTs, Day Centres and assertive outreach teams as alternatives to inpatient admission in a crisis.

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

"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."²¹

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."²²

Successive action plans were created to implement the Bamford Vision – *Delivering the Bamford Vision: Action Plan (2009–2011)* and *Delivering the Bamford Vision Action Plan 2012–2015*. Public monitoring of progress is done by the Bamford Monitoring Group, which is made up of patients and carers, and the 2012–2015 framework has subsequently been extended for a year to allow for an evaluation to take place.

The last monitoring report published was for 2014, where 81% of the 76 targets were considered to be on target.²³ Although the Commission has been told that to date the key targets for completing resettlement of long-stay mental health patients had not been achieved, it was also told that the target of shifting 60% of mental health expenditure to community settings has very recently been met.

Recent years have also seen some significant policy developments in respect of quality with the creation of Service Frameworks for Mental Health, the introduction of the Productive Ward approach and the Quality 2020 strategy, both of which are described in Chapter Three.

Wider health and social care policy

Mental health fits within the wider framework of health and social care policy and organisation and is affected by developments in these areas.

In December 2011 *Transforming Your Care* was published. This aimed to reform and reshape health and social care in the Region by increasing the amount of care carried out in the community, encouraging early intervention and increasing the personalisation of care.²⁴ In relation to mental health, the Transforming Your Care strategy broadly reflected the aims of the existing Bamford implementation work, with key initiatives for acute mental health identified as the continued reduction of mental health beds in line with the continuing resettlement of long stay mental health patients and the consolidation of inpatient acute psychiatric care into six admission units, one in each of the five Trusts plus an additional unit in the Western area.²⁵

The 2011-2015 Programme for Government cited “*acting to improve the mental health and wellbeing of our people*” as an explicit element of their broader priority of “growing a sustainable economy and investing in the future.”²⁶ Although the 2016-2021 Programme for Government had not been published when this report went to press, the Commission is pleased to note that improving mental health is said to feature as an objective.²⁷

Table 1.1: UK suicide rate in the general population per 100,000 (2003-2013)³²

	Northern Ireland	England	Wales	Scotland
2003	11.1	10.6	14.4	17.6
2004	15.9	10.5	12	18.6
2005	15.4	10	12	17.1
2006	15	9.4	11.1	16.8
2007	17	9.4	11.1	18.1
2008	16.7	10.1	11.3	18.1
2009	14.9	9.4	10.5	16.3
2010	19.1	9.5	11.2	16.6
2011	16	9.6	11.7	18.9
2012	16.5	10.3	13	17.5
2013	18.6	10.1	13	16.8

Source: The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (2015).
Annual Report: England, Northern Ireland, Scotland and Wales.

Prevention of suicides

The level of suicides in Northern Ireland is well recognised as a major problem although, as this discussion will show, it is not primarily a problem with mental health services but a much wider social one. Most suicides are of people who have no contact with mental health services and may not be mentally ill – although this, of course, raises questions about whether mental health services are reaching everyone who needs them, and also whether people feel able to use them, as stigma continues to be associated with seeking help for mental health problems.

The high prevalence of mental health problems and high levels of suicides can in part be attributed to life in a post-conflict country where these problems are emerging as life returns to normality and in part is also associated with high levels of unemployment and social deprivation.²⁸ There was a dramatic rise in suicides in Northern Ireland from 2003-2013 from 11.1/100,000 – 18.6/100,000. Although the rate reached a peak in 2010 (19.1/100,000) and then fell, the National Confidential Inquiry on Suicide and Homicide estimates that there will be a further rise when the figures for 2013 are calculated to 18.6/100,000.²⁹ For comparison, the rate in the Republic of Ireland was 11.8/100,000 in 2012.³⁰

Some progress on suicides appears to have been made through the *Protect Life Suicide Prevention Strategy and Action Plan 2006-2011*³¹ and the subsequently refreshed 2012–March 2014 Strategy, although causality is difficult to determine. Following slight reductions there has, however, been an upward turn in the last two years, as shown in

Table 1.1, above, which also presents figures for England, Scotland and Wales for comparison. Box 1.3 describes the main actions taken under the Protect Life Strategy and key points from a formal evaluation of its progress.

It is significant that the number of patient suicides (defined as people who were in contact with mental health services within 12 months before their death) between 2003 and 2013 was 27% with only 4% being inpatients at the time and 5% being under the care of CRHTs. There was no rise in these suicides over the period during which there was a dramatic increase in the general population.³⁴

The National Confidential Inquiry assessed average rates of suicide in the general population in the period 2011-2013 and found there were only small variations by Health and Social Care Trust at the time of death. The highest rate of suicide was in the Southern Area (16.9/100,000) and the lowest in the Western Area (15.8/100,000).³⁵

The high rates in the general population, together with evidence of disproportionately high rates amongst young people and people with a dual diagnosis of alcohol or substance misuse demonstrate the importance of the largely community based approach adopted by the Protect Life Strategy. Discussions with public health professionals and clinicians locally suggest that this needs to be continued and could benefit from being embedded in a wider cross-government health and well-being strategy for Northern Ireland. Suicide is not a stand-alone public health problem but is linked to the higher rates of mental health in the Region and needs to be tackled in this wider context.

Box 1.3: The Protect Life Strategy³³

The aim of the Protect Life Strategy launched in 2006 was to reduce the suicide rate in Northern Ireland by 15% by 2011 by:

- 1 Raising awareness of mental health and well-being issues
- 2 Ensuring early recognition of mental ill health and providing appropriate follow-up action by support services
- 3 Developing co-ordinated, effective, accessible and timely response mechanisms for those seeking help
- 4 Providing appropriate training for people dealing with suicide and mental health issues
- 5 Enhancing the support role currently carried out by the voluntary/community sectors, bereaved families and individuals who have made previous suicide attempts
- 6 Supporting the media in the development and implementation of guidelines for a suitable response to suicide-related matters
- 7 Providing support for research and evaluation of relevant suicide and self-harm issues
- 8 Restricting access, where possible, to the means of completing suicide.

The strategy targeted specific groups and communities in the population – including people who self-harm or misuse drugs and alcohol, young males and prisoners – and established a very wide ranging action plan that covered:

- Community-led suicide prevention and bereavement support services
- Local research into suicide
- GP depression awareness training
- Enhanced crisis intervention services
- Public information campaigns
- The Lifeline crisis referral telephone helpline
- A Deliberate Self-Harm Registry
- Development of local suicide cluster response plans
- Development of suicide cluster emergency response plans.

The evaluation of the Protect Life Strategy found that progress had been mixed, with only about one in five actions progressing in line with plans and one in ten having made limited progress. Least progress had been made where a cross-departmental or inter-agency approach was needed. The 15% reduction in suicides was not achieved with the suicide rate being higher than the baseline for four out of the five years covered by the strategy.

Organisational structures

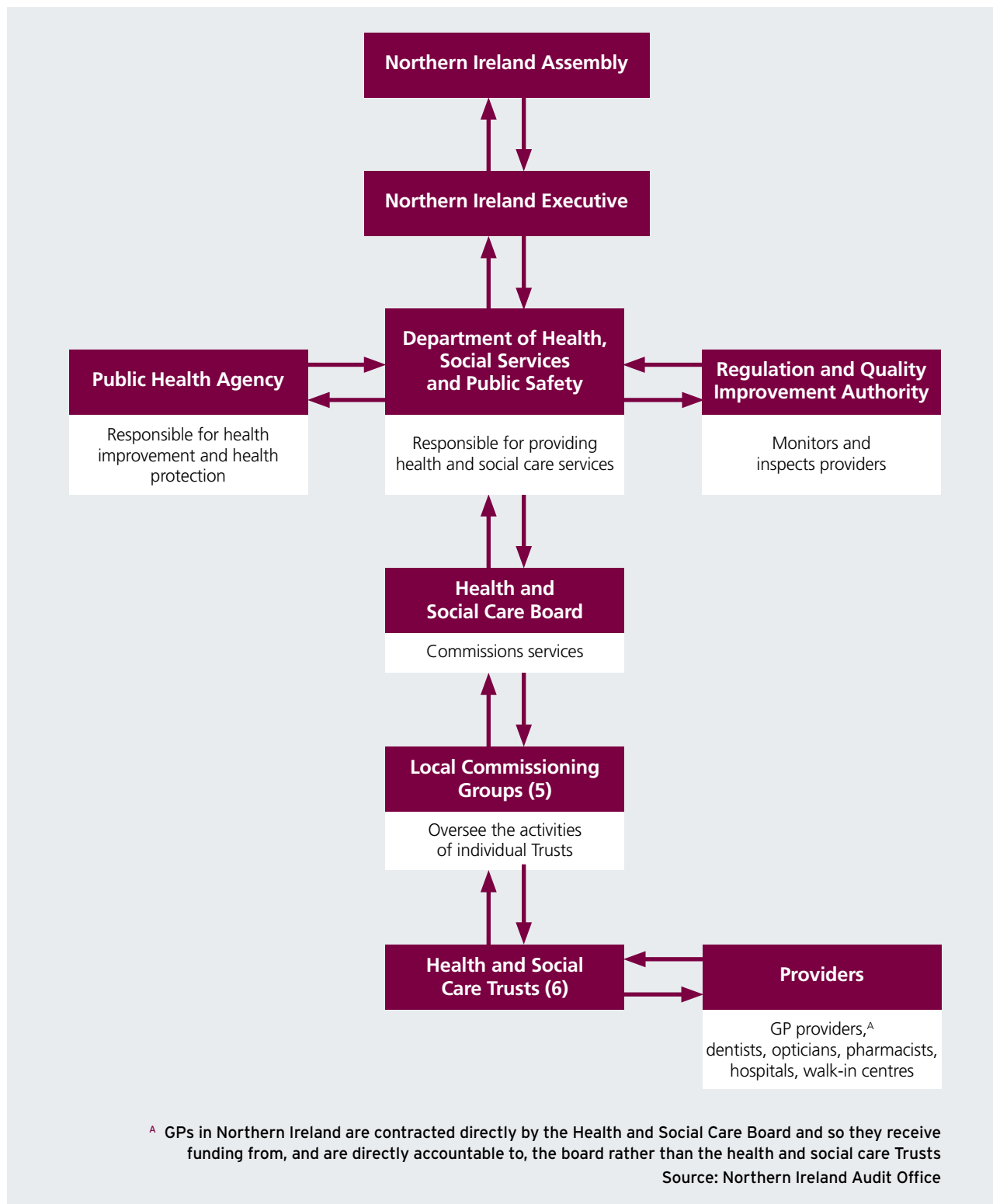
The most distinctive feature of the Northern Ireland system within the UK is that it has had an integrated structure of health and social care since the 1970s. This is shown in Figure 1.3.

This integrated structure has significant advantages as described in a 2013 King's Fund report which noted particular strengths in:

- **Delivery of Integrated Care:** Having a single employer and budgets, shared strategies and systems means Northern Ireland has avoided many of the inter-agency tensions which have been challenging in developing the Care Pathway Approach in England.
- **Integrated Management:** The position of 'programme manager' or 'team leader' is open to a range of professions. This enables and encourages health care professionals to move across to management roles, widening the pool of potential managerial talent.
- **Hospital Discharges:** Smooth transfer from hospital is considered a key achievement of integrated care more broadly. However, delayed discharges from mental health settings are still seen as a problem by many clinicians.³⁶

However, the report noted that there was inequality between health and social care – with the health agenda perceived as dominant, both in terms of funding and the attention given to meeting performance targets. The report concluded that *"the integrated health and social care system has not realised its full potential and the opportunities provided by the structural organisation have not been fully exploited."*³⁷ It also commented on the lack of evidence and data which will be returned to in Chapter Five, noting that *"a key issue in Northern Ireland is the lack of robust evidence to assess and evaluate the outcomes of this unique system. The effectiveness or otherwise of the integrated system is difficult to assess owing to the weakness of the existing data, which is particularly limited in terms of evidence of improved patient outcomes."*³⁸

Figure 1.3: The health and social care system



The 2014 Donaldson Report, set up to examine the arrangements to improve the quality and safety of care, criticised the organisation of the whole system more generally and commented on the fragmentation of services and the large number of silos.³⁹ Following the Donaldson Report the Minister of Health established an expert panel to consider the best model for health and social care services in Northern Ireland which would address these issues. This panel led by Professor Rafael Bengoa has subsequently set out 13 working principles.⁴⁰ It is not yet clear how this work will be carried forward within the new Assembly, although anything arising from it will impact on mental health.

The Commission was told that although it is very helpful to have social care and health care provided in an integrated fashion, the fact that a separate department (the Northern Ireland Housing Executive) manages housing and homelessness means that many problems persist with access to housing. The particular need for more supported housing is discussed in Chapter Two.

Constituent organisations

There are six Health and Social Care Trusts in Northern Ireland which provide secondary, tertiary and community services alongside primary care. Five provide local health and social care services in Northern Ireland while the sixth is the 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. The Trusts are:

- Belfast Health and Social Care Trust
- Northern Health and Social Care Trust
- South Eastern Health and Social Care Trust
- Southern Health and Social Care Trust
- Western Health and Social Care Trust⁴¹

There are a number of other regulatory and supporting structures, including:⁴²

- The Public Health Agency – this oversees health and social well-being improvement, health protection, public health support to commissioning and policy development, research and development.
- The 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.

- Guideline Audit and Implementation Network (GAIN) – 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.ⁱⁱⁱ
- The Regulation and Quality Improvement Authority (RQIA) is responsible for inspecting mental health services in Northern Ireland.

Local government responsibilities are very limited with key responsibilities divested to statutory bodies. The Northern Ireland Housing Executive, for example, manages housing and homelessness. However, The Commission notes that increased powers have been devolved to the new Councils (established in April 2015). Councils are committed to working strategically with other statutory partners such as Health and Social Care Trusts to improve the health and well being of their populations.

Commissioning

The Health and Social Care Board leads the commissioning of local mental health services. Falling under the responsibility of the Department of Health, Social Services, and Public Safety for Northern Ireland, (renamed the Department of Health from May 2016) this Board has three main functions:⁴³

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

The Health and Social Care Board oversees five Local Commissioning Groups. 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.⁴⁴

ⁱⁱⁱ Since April 2015 GAIN has been based at the RQIA

Each Local Commissioning Group covers the same geographical area as its respective Health and Social Care Trust, and draws its membership from primary care, elected counsellors, the community and voluntary sector, public health, nursing, social work, and allied health professionals.⁴⁵

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.⁴⁶

The Donaldson Report was very critical of Northern Ireland's commissioning system:

"It is clear, though, that the Northern Ireland approach to commissioning is not currently working well, and that this is surely affecting the quality of services that are being provided.

At 1.8 million, the population of Northern Ireland is relatively small to justify what is a quite intricately designed health and social care management structure. The problem for Northern Ireland is that it has gone just partially down the commissioning path. It does not have the benefits of a sophisticated commissioning system, yet has the downside of increased complexity and overhead costs. The worst of both worlds.

Northern Ireland's five Local Commissioning Groups are not like England's Clinical Commissioning Groups. The Local Commissioning Groups have a primary focus on identifying opportunities for local service improvement. They have very few resources and, in effect, are advisers and project managers rather than commissioners. England's Clinical Commissioning Groups, by stark contrast, have a high degree of control over resource allocation.

We recommend that the commissioning system in Northern Ireland should be redesigned to make it simpler and more capable of reshaping services for the future."⁴⁷

More recently, in November 2015, the then Health Minister Simon Hamilton proposed making major changes.⁴⁸ Extracts from his statement of 4th November 2015 are shown in Box 1.4.

Box 1.4: Extracts from former Health Minister Simon Hamilton's statement of 4th November 2015⁴⁹

"The administration of Health and Social Care suffers from a common Northern Ireland public sector problem. It is too big. It is too bureaucratic. And it doesn't deliver best value.

From conversations I have had with staff it is clear that many feel that our commissioning system doesn't work, they don't understand it and, worst of all, it actually inhibits innovation.

We have too many layers in our system. There are just too many entities that create blocks to the implementation of reforms, present opportunities to 'pass the buck' and result in a genuine lack of proper accountability.

I will propose that we close down the Health and Social Care Board. I believe we no longer need a standalone organisation like the Board... many of the Board's existing functions, and staff, would revert back to the Department."

Equal priority for mental and physical health

The two biggest themes that emerged from the Commission's deliberations were the importance of giving equal priority to mental and physical health and the need to improve the whole way the system functions. Subsequent chapters will fill out the detail: showing, for example, in Chapter Two that too many patients are being cared for in the wrong part of the system. This chapter concludes with recommendations about parity of esteem, improvements to commissioning and the steps that can be taken to create a single service for mental health in Northern Ireland.

Mental health has now been given equal priority with physical health within all health policies in England although it will take some time for this to be achieved in practice. The Commission would argue strongly that the same policy needs to be adopted in Northern Ireland for three main reasons:

- While there is much good care being delivered, too many patients are having great difficulty accessing services or are cared for in inappropriate settings with many being admitted or staying longer in inpatient care than is necessary. This would not be tolerated if the same thing were happening to people critically ill with serious physical health problems such as stroke or heart attacks.
- Mental health diseases can be killer diseases. People with severe mental health problems live significantly shorter lives and have poorer access to physical health care.⁵⁰
- There is a higher level of need than elsewhere in the UK.

Without it being given equal priority, the current situation is likely to continue with funding for mental health proportionately lower than elsewhere in the UK – despite the higher need – and the good policy and practice that has been developed from the Bamford review onwards not being fully implemented.

The expression ‘parity of esteem’ between mental and physical health is used to denote a wider set of issues. A 2013 Royal College of Psychiatrists report describes it thus:

“Parity of esteem means that, when compared with physical healthcare, mental healthcare is characterised by:

- *equal access to the most effective and safest care and treatment*
- *equal efforts to improve the quality of care*
- *the allocation of time, effort and resources on a basis commensurate with need*
- *equal status within healthcare education and practice*
- *equally high aspirations for service users; and*
- *equal status in the measurement of health outcomes.”*⁵¹

Equal priority or parity of esteem is therefore not only about funding levels but also about how the whole system operates, what incentives there are and what leadership is provided. Three key aspects are discussed below: protected funding, performance targets and publication of results, and leadership.

The Commission heard from many people and saw evidence that mental health budgets were sometimes used to bail-out overspends in other areas. This was the single most important issue facing the service in the opinion of several people. This practice not only disadvantaged mental health but made it difficult to plan with any security, and introduced perverse incentives in both mental health and physical health.

Turning to performance targets, the Commission recommended in its English report that a four hour maximum wait between the decision to treat and admission or acceptance by a CRHT should be introduced to help achieve equality with physical health and ensure that there is public monitoring of performance.⁵²

The Commission was aware that there was a two hour target for assessment which was met in more than 90% of instances. It spoke to several clinicians who thought that this additional four hour target would improve care, although they suggested it be introduced without punitive performance management elements and with flexibility to allow for exceptions, such as when a patient wanted to delay admission for practical reasons. They also suggested that it be complemented by each Trust meeting the standard of having a Home Treatment Team available on a 24hr basis, providing treatment and not just assessment. The Commission’s view is that this target and standard should be established, and that data should be collected and published alongside their equivalents for physical health so that any failings to deliver become visible rather than hidden as now.

Similarly, the Commission had a great deal of discussion about the need for a national champion, leader or advocate for mental health. This could take the form of an independent role external to government, an internal governmental role similar to the National Clinical Director for Mental Health post in England, or potentially both working in a complementary fashion.

The recent Queen’s University Belfast *Regress? React? Resolve?* report which drew upon stakeholder research states that: *“notwithstanding the progress that had been achieved since the Bamford Review... respondents identified that a vacuum in leadership had developed post-Bamford”*.⁵³

Stakeholders were of the view that new leadership would be crucial in sustaining the progress that had already been made in realising the Bamford Vision and achieving much needed, further improvements to services leading the authors to recommend *“the establishment of an independent Mental Health Champion for Northern Ireland whose role would be to defend the rights and interests of people with mental health problems.”*⁵⁴

This approach has been supported by the Royal College of Psychiatrists in Northern Ireland which has proposed that a *“Mental Health Champion (following precedents in Scotland and Ireland) should be tasked with developing a fit-for-purpose, comprehensive mental health service across Northern Ireland, building on the successes of mental health initiatives of recent years.”*⁵⁵ A broad range of mental health charities in Northern Ireland including Aware; CAUSE; Cruse; MindWise; Nexus NI; Praxis Care; Relate NI and The Rainbow Project have also supported this proposal.⁵⁶

A single mental health service

The Commission listened carefully to the arguments for creating a single mental health Trust to cover the whole of Northern Ireland and recognises the potential advantages of having a single organisation and leadership that focuses all its efforts on mental health. However, it also recognised the considerable disruption this would cause – exacerbated by pressure from local communities to keep control of their local services – and the fact that this would tend to damage the links with physical health services and the local community. The Commission believes that it is essential that decisions about organisational and service configuration – and the associated questions of leadership – are taken as soon as possible in the life of the new Assembly to reduce uncertainty and allow the benefits of the chosen options to be realised. It urges the Assembly to press ahead with the expert panel review and make decisions as a matter of urgency.

In the meantime, however, the Commission believes that the Department should move towards creating a *single mental health service* with clear leadership, funding, data, standards, and accountability. Experience with managed clinical or care networks elsewhere in the UK shows that this need not necessarily involve creating a single organisation but will need to be strong enough to make decisions about services – and ensure they are implemented – and to equalise pressures, access and standards across the whole system.

Whatever the outcome of deliberations about targets and leadership, the Commission believes that there is a clear opportunity here for the Members of the new Assembly to take the political lead in raising the profile and priority of mental health and ensuring it receives the support and leadership that befits the level of need in Northern Ireland.

The Commission recommends that:

1. Parity of esteem. Mental health needs to be explicitly given equal priority with physical health by both the Department of Health and the Assembly. This would mean that mental health patients should have the same levels of access and standards as for physical health, a four hour maximum wait target between the decision to treat and admission or acceptance by a CRHT should be introduced alongside a 24hr Home Treatment Team availability standard, data on performance should be published, funding must be protected, and there needs to be clear unified leadership across the whole service.

2. A single mental health service for Northern Ireland. The Department of Health, the Public Health Agency and the five Health and Social Care Trusts need to find ways to create a single service across Northern Ireland with less fragmentation of services, the adoption of common systems and standards and the development of a managed care network to enable more effective cross-boundary working and improve quality and efficiency.

References

- ¹ Information Analysis Directorate, Department of Health, Social Services, and Public Safety (2015). *Health Survey Northern Ireland: First Results 2014/15*. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hsni-first-results-14-15.pdf> [Accessed 11 May 2016]
- ² Action Mental Health (n.d). *About Mental Illness in Northern Ireland*. Available at: <http://www.amh.org.uk/about/> [Accessed 12 May 2016]
- ³ Friedli, L & Parsonage, M (2007). *Mental Health Promotion: Building an Economic Case*. Belfast: NIAMH. Available at: http://www.chex.org.uk/media/resources/mental_health/Mental%20Health%20Promotion%20-%20Building%20an%20Economic%20Case.pdf [Accessed 11 May 2016]
- ⁴ The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (2015). *Annual Report: England, Northern Ireland, Scotland and Wales*. University of Manchester Available at: <http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked2.pdf> [Accessed 12 May 2016]
- ⁵ Department of Health, Social Services, and Public Safety (2010). *Reshaping the System: Implications for Northern Ireland's Health and Social Care Services of the 2010 Spending Review (McKinsey Report)*. Belfast: Department of Health, Social Services, and Public Safety. Quoted in Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. & Faulkner, L. (2015). *Regress? React? Resolve?: An evaluation of mental health service provision in Northern Ireland*. Available at http://pure.qub.ac.uk/portal/files/17051927/Regress_React_Resolve.pdf [Accessed 17 May 2016]
- ⁶ Hospital Information Branch (DHSSPSNI) (2015). *Annual Hospital Statistics: Mental Health and Learning Disability 1998/9–2014/15*. Belfast: Department of Health, Social Services, and Public Safety Available at: <https://www.dhsspsni.gov.uk/topics/dhssps-statistics-and-research-mental-health-and-learning-disabilities/mental-health-and> [Accessed 18 April 2016]
- ⁷ Hospital Information Branch (DHSSPSNI) (2015). *Annual Hospital Statistics: Mental Health and Learning Disability 1998/9–2014/15*. Belfast: Department of Health, Social Services, and Public Safety Available at: <https://www.dhsspsni.gov.uk/topics/dhssps-statistics-and-research-mental-health-and-learning-disabilities/mental-health-and> [Accessed 18 April 2016]
- ⁸ Hospital Information Branch (DHSSPSNI) (2015). *Annual Hospital Statistics: Mental Health and Learning Disability 1998/9–2014/15*. Belfast: Department of Health, Social Services, and Public Safety Available at: <https://www.dhsspsni.gov.uk/topics/dhssps-statistics-and-research-mental-health-and-learning-disabilities/mental-health-and> [Accessed 18 April 2016]
- ⁹ Health and Social Care Board (2012). *Annual Report: 1st April 2011–31st March 2012*. Belfast: Health and Social Care Board. Available at: <http://www.hscboard.hscni.net/publications/Annual%20Reports/451%20Annual%20Report%20%202011-2012%20-%20PDF1MB.pdf> [Accessed 13 May 2016]
- ¹⁰ Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. & Faulkner, L. (2015). *Regress? React? Resolve?: An evaluation of mental health service provision in Northern Ireland*. Available at: http://pure.qub.ac.uk/portal/files/17051927/Regress_React_Resolve.pdf [Accessed 17 May 2016]
- ¹¹ Department of Health, Social Services, and Public Safety (2014a). *Bamford Action Plan 2012–15: Monitoring Report*. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/publications/delivering-bamford-vision-action-plan-2012-15> [Accessed 12 May 2016]
- ¹² Friedli, L & Parsonage, M (2007). *Mental Health Promotion: Building an Economic Case*. Belfast: NIAMH Available at: http://www.chex.org.uk/media/resources/mental_health/Mental%20Health%20Promotion%20-%20Building%20an%20Economic%20Case.pdf [Accessed 11 May 2016]
- ¹³ HQIP and the Royal College of Psychiatrists (2014). *Report of the second round of the National Audit of Schizophrenia (NAS2) 2014 Report for Northern Ireland*. Available at: <http://www.rcpsych.ac.uk/pdf/NAS2%20NI%20national%20report%20FINAL.pdf> [Accessed 12 May 2016]
- ¹⁴ Bamford Review of Mental Health and Learning Disability (2005). *A Strategic Framework for Adult Mental Health Services, Belfast: Department of Health, Social Services, and Public Safety*. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf> [Accessed 11 May 2016]
- ¹⁵ Bamford Review of Mental Health and Learning Disability (2005). *A Strategic Framework for Adult Mental Health Services*, p13. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf> [Accessed 11 May 2016]
- ¹⁶ Bamford Review of Mental Health and Learning Disability (2005). *A Strategic Framework for Adult Mental Health Services*, p53. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf> [Accessed 11 May 2016]
- ¹⁷ Bamford Review of Mental Health and Learning Disability (2005). *A Strategic Framework for Adult Mental Health Services*. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf> [Accessed 11 May 2016]
- ¹⁸ Bamford Review of Mental Health and Learning Disability (2005). *A Strategic Framework for Adult Mental Health Services*, p43. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf> [Accessed 11 May 2016]

- 19 Bamford Review of Mental Health and Learning Disability (2005). *A Strategic Framework for Adult Mental Health Services*, p78. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf> [Accessed 11 May 2016]
- 20 Bamford Review of Mental Health and Learning Disability (2005). *A Strategic Framework for Adult Mental Health Services*, p29. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf> [Accessed 11 May 2016]
- 21 Bamford Review of Mental Health and Learning Disability (2005). *A Strategic Framework for Adult Mental Health Services*, p25. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf> [Accessed 11 May 2016]
- 22 The Bamford Review of Mental Health and Learning Disability (2007). *A Comprehensive Legislative Framework*. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/legal-issue-comprehensive-framework.pdf> [Accessed 11 May 2016]
- 23 Department of Health, Social Services, and Public Safety (2014a). *Bamford Action Plan 2012–15: Monitoring Report*. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/publications/delivering-bamford-vision-action-plan-2012-15> [Accessed 12 May 2016]
- 24 Department of Health, Social Services, and Public Safety (2011). *Transforming Your Care: A Review of Health and Social Care in Northern Ireland*. Belfast: Department of Health, Social Services, and Public Safety. Available at: <http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSCin-NI.pdf> [Accessed 11 May 2016]
- 25 Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. & Faulkner, L. (2015). *Regress? React? Resolve?: An evaluation of mental health service provision in Northern Ireland*. Available at: http://pure.qub.ac.uk/portal/files/17051927/Regress_React_Resolve.pdf [Accessed 17 May 2016]
- 26 Northern Ireland Executive (2012b). *Programme for Government 2011–2015*, p30. Belfast: Northern Ireland Executive. Available at: <https://www.northernireland.gov.uk/sites/default/files/publications/nigov/pfg-2011-2015-report.pdf> [Accessed 31 May 2016]
- 27 BBC News (2016). *NI Assembly: Stormont departments 'should be allocated next week', says McGuinness*. Available at: <http://www.bbc.co.uk/news/uk-northern-ireland-politics-36307116> [Accessed 24 May 2016]
- 28 Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. & Faulkner, L. (2015). *Regress? React? Resolve?: An evaluation of mental health service provision in Northern Ireland*. Available at: http://pure.qub.ac.uk/portal/files/17051927/Regress_React_Resolve.pdf [Accessed 17 May 2016]
- 29 The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (2015). *Annual Report: England, Northern Ireland, Scotland and Wales*. University of Manchester. Available at: <http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked2.pdf> [Accessed 12 May 2016]
- 30 RTE Investigations Unit (2015). *Suicide – The Facts*. Available at: <http://www.rte.ie/iu/suicide/> [Accessed 06.06.16]
- 31 Department of Health, Social Security and Public Safety (2006). *Protect life: a shared vision: the Northern Ireland suicide prevention strategy and action plan 2006–2011*. Belfast: DHSSPSNI
- 32 The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (2015). *Annual Report: England, Northern Ireland, Scotland and Wales*. University of Manchester. Available at: <http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked2.pdf> [Accessed 12 May 2016]
- 33 Department of Health, Social Services and Public Safety (2012). *Evaluation of the implementation of the NI protect life suicide prevention strategy and action plan 2006–11*. Available at: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/suicide-prevention-protect-life-evaluation-report-2012_0.pdf [Accessed 17 May 2016]
- 34 The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (2015). *Annual Report: England, Northern Ireland, Scotland and Wales*. University of Manchester. Available at: <http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked2.pdf> [Accessed 12 May 2016]
- 35 The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (2015). *Annual Report: England, Northern Ireland, Scotland and Wales*. University of Manchester. Available at: <http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked2.pdf> [Accessed 12 May 2016]
- 36 Ham, C., Heenan, J., Longley M., & Steel, D (2013). *Integrated care in Northern Ireland, Scotland and Wales: Lessons for England*. London: The Kings Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/integrated-care-in-northern-ireland-scotland-and-wales-kingsfund-jul13.pdf [Accessed 31 May 2016]
- 37 Ham, C., Heenan, J., Longley M., & Steel, D (2013). *Integrated care in Northern Ireland, Scotland and Wales: Lessons for England*, p21. London: The Kings Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/integrated-care-in-northern-ireland-scotland-and-wales-kingsfund-jul13.pdf [Accessed 31 May 2016]
- 38 Ham, C., Heenan, J., Longley M., & Steel, D (2013). *Integrated care in Northern Ireland, Scotland and Wales: Lessons for England*, p21. London: The Kings Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/integrated-care-in-northern-ireland-scotland-and-wales-kingsfund-jul13.pdf [Accessed 31 May 2016]

- ³⁹ Donaldson, L., Rutter P., & Henderson M. (2014). *The Right Time, The Right Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland*. Belfast: Department of Health, Social Services, and Public Safety. Available at: https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf [Accessed 31 May 2016]
- ⁴⁰ Department of Health, Social Services and Public Safety (2016). *Working Principles for HSC Remodelling*. Available at: <https://www.health-ni.gov.uk/publications/working-principles-hsc-remodelling> [Accessed 25 May 2016]
- ⁴¹ Binleys. (2015). *Binley's NHS Guide. Winter-Spring 2015*. Essex: Wilmington Healthcare Limited
- ⁴² Binleys. (2015). *Binley's NHS Guide. Winter-Spring 2015*. Essex: Wilmington Healthcare Limited
- ⁴³ O'Neill C, McGregor P, Merkur S. (2012). United Kingdom (Northern Ireland): Health system review. *Health Systems in Transition*, 14(10): pp.1– 91
- ⁴⁴ Binleys. (2015). *Binley's NHS Guide. Winter-Spring 2015*. Essex: Wilmington Healthcare Limited
- ⁴⁵ Health and Social Care Board (n.d). Local Commissioning Groups. Available at: <http://www.hscboard.hscni.net/LCG/> [Accessed 31 May 2016]
- ⁴⁶ Health and Social Care Board (n.d). Local Commissioning Groups. Available at: <http://www.hscboard.hscni.net/LCG/> [Accessed 31 May 2016]
- ⁴⁷ Donaldson, L., Rutter P., & Henderson M. (2014). *The Right Time, The Right Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland*. Belfast: Department of Health, Social Services, and Public Safety. Available at: https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf [Accessed 31 May 2016]
- ⁴⁸ Northern Ireland Executive (2015). *Hamilton Outlines Ambitious Vision For Health And Social Care In Northern Ireland*. Available at: <https://www.health-ni.gov.uk/news/hamilton-outlines-ambitious-vision-health-and-social-care-northern-ireland> [Accessed 5 May 2016]
- ⁴⁹ Northern Ireland Executive (2015). *Hamilton Outlines Ambitious Vision For Health And Social Care In Northern Ireland*. Available at: <https://www.health-ni.gov.uk/news/hamilton-outlines-ambitious-vision-health-and-social-care-northern-ireland> [Accessed 5 May 2016]
- ⁵⁰ Wahlbeck, K., Westman, J., Nordentoft, M., Gissler, M., & Laursen, T.M. (2011). Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. *Br J Psychiatry*, 199: pp.453-58
- ⁵¹ The Royal College of Psychiatrists (2013). *Whole-person care: from rhetoric to reality Achieving parity between mental and physical health*, p3. London: Royal College of Psychiatrists. Available at: <http://www.rcpsych.ac.uk/pdf/Parity%20of%20esteem%20sum.pdf> [Accessed 13 May 2016]
- ⁵² Crisp, N., Smith, G. & Nicholson, K. (eds.) (2016). *Old Problems, New Solutions – Improving Acute Psychiatric Care for Adults in England* London: The Commission on Acute Adult Psychiatric Care
- ⁵³ Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. & Faulkner, L. (2015). *Regress? React? Resolve?: An evaluation of mental health service provision in Northern Ireland*, p104. Available at: http://pure.qub.ac.uk/portal/files/17051927/Regress_React_Resolve.pdf [Accessed 17 May 2016]
- ⁵⁴ Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. & Faulkner, L. (2015). *Regress? React? Resolve?: An evaluation of mental health service provision in Northern Ireland*, p4. Available at: http://pure.qub.ac.uk/portal/files/17051927/Regress_React_Resolve.pdf [Accessed 17 May 2016]
- ⁵⁵ The Royal College of Psychiatrists in Northern Ireland (2016). *Manifesto for the 2016 Northern Ireland Assembly election*, p2. Belfast: The Royal College of Psychiatrists Available at: <http://www.rcpsych.ac.uk/pdf/Manifesto%20website%20version.pdf> [Accessed 6 May 2016]
- ⁵⁶ Aware NI (2016). *Charities call on the next NI Executive to have fair and equal policies for those living with mental ill-health*. Available at: <http://www.aware-ni.org/news/charities-call-on-the-next-ni-executive-to-have-fair-and-equal-policies-for-those-living-with-mental-ill-health.html> [Accessed 6 May 2015]

02

The mental health system

Summary

This chapter describes the mental health system and the range of services available to patients. It also describes a survey undertaken of all the acute adult psychiatric wards in Northern Ireland. This shows how fragmentation of provision and the lack of some vital community and specialist services cause problems for patients, carers and staff and means that many patients are cared for in the wrong setting.

It recommends the adoption of a systematic process to ensure there are effective systems and sufficient capacity in different types of services to enable patients to be cared for in the most appropriate setting.

The mental health system

People with mental health problems are cared for in a range of different services by different providers – including, in many instances, themselves and their own carers. There are differences, too, in need and provision between rural and urban areas as well as differences due to more local factors relating to employment and the nature of the local community and its history.

This report uses the concept of the mental health system to embrace all organisations and services which have as a principal role the provision of care or facilities for people with mental illnesses. In addition it recognises the influence that other organisations and services dealing with, for example, employment, welfare benefits and criminal justice have on the lives of people with mental illnesses and their families.

Given this context it is fundamentally important that people working in mental health understand how systems work in the way described in Box 2.1.

This approach means that mental health leaders need to always be thinking in systems terms about how to improve care and treatment. In doing so, they will need to adopt the consultative approach advocated by the WHO, as in Box 2.1, and work through the changes in behaviour, processes and systems, measurement, regulation and incentives needed to make and support improvements.

Given this complexity, it is difficult to provide a simple description or map of mental health services. However, it may be useful to think of them in terms of five groupings:

- Primary care, where most people are treated most of the time – and where they may live at home or in residential or other care and receive support from their GP.
- Community-based services designed to help people maintain their normal roles in society – this would include, for example, assertive outreach teams, social housing and supported accommodation, community mental health services, rehabilitation teams, drugs and alcohol teams, and voluntary and self-help organisations.
- Crisis care responding to urgent needs – this includes Crisis Resolution and Home Treatment teams (CRHTs) as well as street triage and other programmes.
- Acute inpatient services.
- Specialist inpatient services for mother and baby care, eating disorders, severe personality disorders and forensic services.

Box 2.1: Systems and system thinking

A well-functioning system is one that is supported by appropriate processes and sub-systems where the different actors understand their relationships with each other and how the system operates. It is therefore essential to adopt a systems thinking approach which recognises that:

- Change in one part of a system affects every other part. Systems do not work linearly with one cause producing one effect. Moreover, the consequences of any changes cannot be predicted accurately and may lead to harmful unintended consequences.
- The more barriers and boundaries within a system, the more difficult it will be for the system to operate well. Every hand-off from one service or organisation to another introduces complications and slows action.
- Systems need to be thought of in very wide terms. In mental health this means not just including the service providers, commissioners, voluntary organisations and patients and carers groups but also the providers of housing, employment services, the criminal justice system, benefit offices and others which influence patients' and carers' lives. Moreover, the regulators, inspectors and auditors, evidence providers such as NICE, Royal Colleges and academic institutions all influence the operation of the system – for better or worse.

The World Health Organisation (WHO) argues that the design of any intervention in a health system needs to consider the potential impact on every major sub-system and to engage all stakeholders in thinking it through and planning the action to be taken.¹ Other commentators similarly argue that health systems need to be understood as complex adaptive systems and that time needs to be spent in identifying how a particular system behaves, what simple rules affect it and how to intervene successfully.²

Acute inpatient services for adults

Adult acute inpatient services are a central part of what is known as the 'care pathway'. This pathway refers to the route that a patient should take while being cared for from their initial presentation with a mental health problem to their ultimate discharge from treatment. It identifies the various different steps and decisions that need to be taken to ensure that they receive high quality care.

The key stages of Northern Ireland's Regional Mental Health Care Pathway³ are shown in Figure 2.1. The Commission understands that a High Intensity Care Pathway for more complex care, which includes acute care for adults, is under development.

Successful implementation of this pathway depends, as can be seen from Figure 2.1, on there being a range of different services and good links between them. In practice there are many variations to this model and enormous variability around the Region in the type and range of services available and in clinical and organisational practice – with the mix of services depending on local policies, funding and the nature and needs of the local population.

The purpose and value of inpatient care as part of the wider system

The Bamford Review provided a clear direction for the system when its Strategic Framework stated 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 (the) most severe episodes of mental disorder, typically psychosis and severe depression."*⁴

The Commission's own definition is broadly similar but draws out some important aspects of the inpatient service. It describes the purpose of inpatient care as being *"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."*⁵

The Bamford Framework stressed that *"mental health and social care should be provided in the community unless there is good reason for not doing so."*⁶ The Commission's Interim Report for England set out the reasons why there is a preference for most treatment to be in the community in order to secure good patient care and recovery:

- If people are admitted for longer than is clinically necessary then there is a risk that they will become institutionalised and find it hard to resume normal life. They may lose jobs, benefits and places to live.
- Recovery and rehabilitation need to take place as near as possible to where they will live. Several people argued that training people in activities of daily living in hospitals does not equip them to use these skills in the community and serves no purpose other than to keep them longer in hospital.
- Costs are far higher in hospital.⁷

This understanding has largely driven the reduction in beds and the development of services seen over recent years in Northern Ireland, the rest of the UK and elsewhere in the world. However, there clearly remains a purpose and value for inpatient care as described above – and a need for it to be delivered to as high a quality as possible within a well-integrated service.

Most clinicians and providers would probably agree with these points and with this broad definition. However, the Commission understands that there are considerable differences as to where, in practice, organisations and clinicians actually place the threshold for admission – and therefore in how many patients are admitted – and significant differences in how they manage services. This reflects the breadth of reasons why admission might be sought, which can be applicable to patients in some circumstances but not in others (for example, depending on the level of support they receive from carers or other services).

Virtually all Trusts use CRHTs as 'gatekeepers' for voluntary admissions to inpatient care, seeking to provide alternative care outside hospital wherever possible. There are risks to patients, carers and the public if patients are treated by CRHTs which are not able to provide adequate, intensive support. It is clearly essential that the composition and capability of CRHTs should reflect the intensive and specialised nature of the role. This requirement does not, however, does not appear to be being met across the Region.

This discussion shows how important it is to get both the balance of provision right between the different elements of the acute service and to ensure that they are able to operate effectively and in a well-coordinated fashion.

Figure 2.1: Northern Ireland's Regional Mental Health Care Pathway

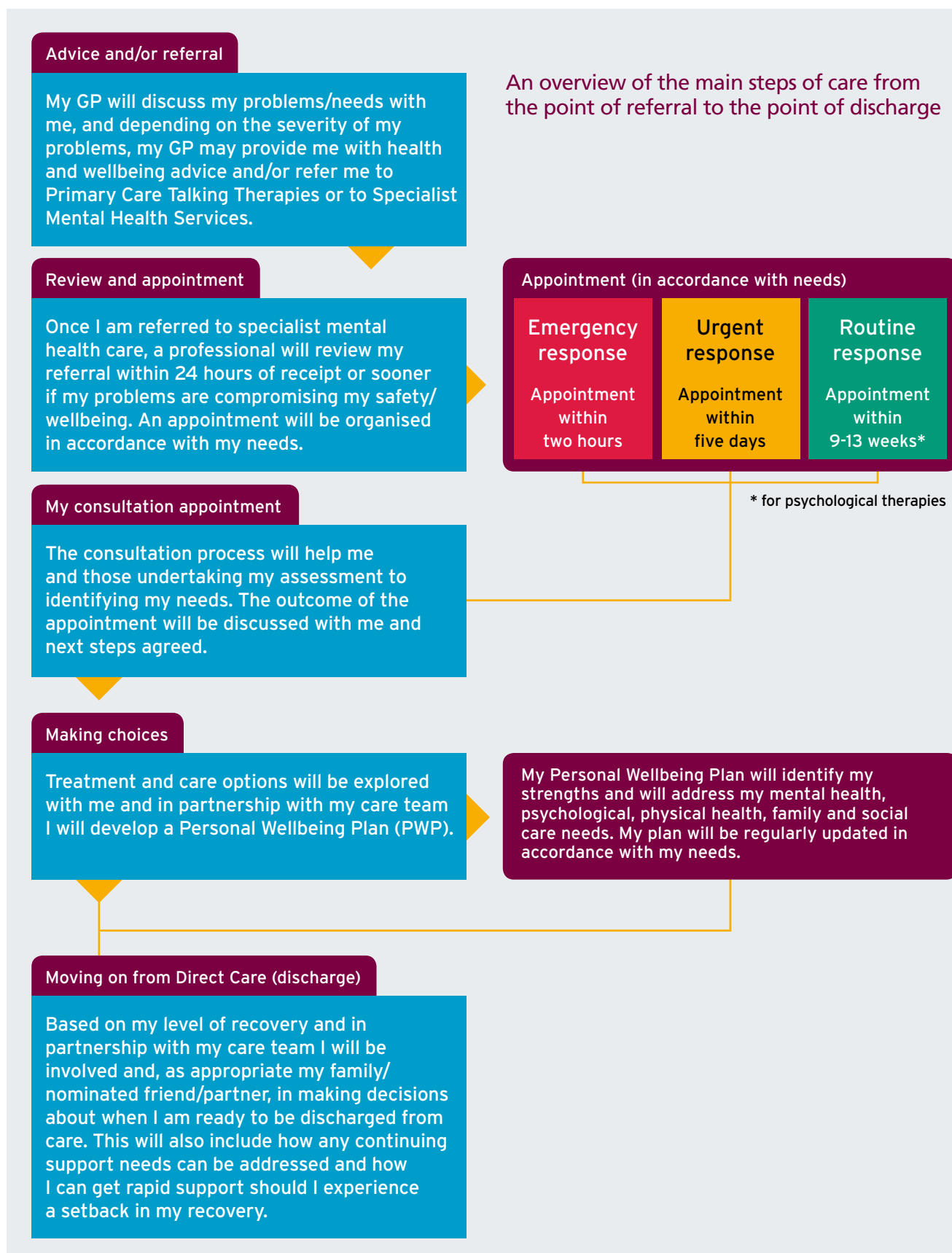
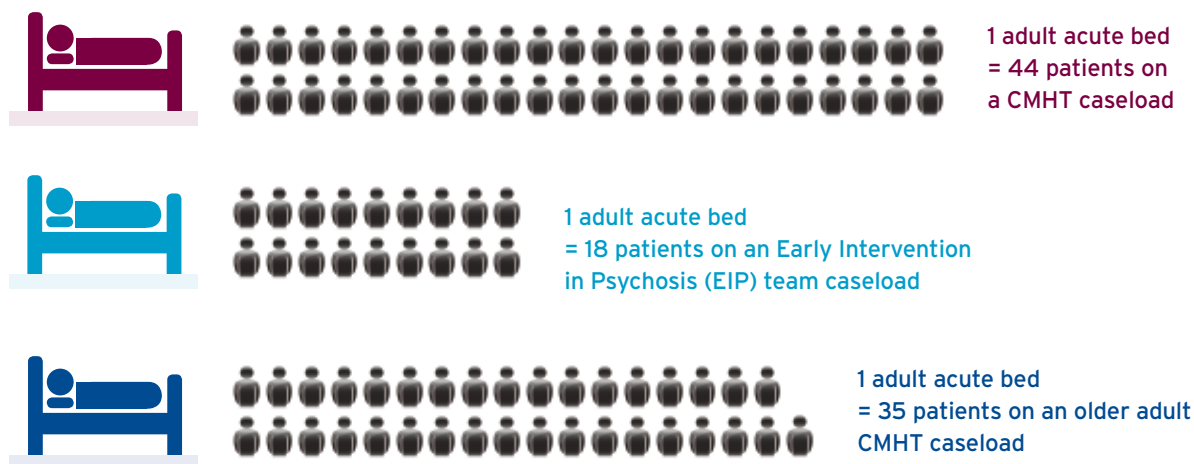


Figure 2.2: The relative costs of beds and other services



Data source: Information received by the Commission from NHS Benchmarking

It is worth noting at this point that there are financial incentives to reduce the size of inpatient services. Figure 2.2 illustrates the relative costs of beds and other provision in England. The costs are likely to be broadly similar in Northern Ireland and give an impression of the likely magnitude of the difference. It shows why it is so important to make sure that wards are only used for people who need to be there – and why delayed discharges, for example, need to be reduced. It also illustrates, however, the risk that cost considerations could play too big a part in decisions about the number of beds needed in an area – and that beds might be closed before suitable alternative acute provision is available. It is essential that all proposals for bed closures are scrutinised for risks as well as for financial considerations, ensuring that adequate alternative care is in place

How well is the system working?

This discussion highlights the importance of there being good CRHTs and community services in order for inpatient services to operate effectively but also emphasises the need for a focus on their quality and on risk management. In a well-functioning system patients will be treated in the right setting, at the right level of quality and with minimised risks. The Commission therefore undertook a survey of acute adult psychiatric wards in Northern Ireland to understand how well the system is working in practice.

The headline findings from the survey are shown below with an outline of the survey methodology provided in Box 2.2. It is important to note that the survey provides a ‘snapshot’ of a particular ten-day period in April-May 2016 rather than a longitudinal analysis.

Headline findings from the Commission’s survey of acute adult psychiatric wards

The survey showed that:

- The average ward is running at full capacity, with average ward occupancy at 95% (excluding patients on leave) and 101% (including patients on leave).
- The majority of respondents (58%) said that there were insufficient acute psychiatric beds in their local area.
- Approximately one in seven patients (15%) surveyed were in an ‘out-of-area’ bed (i.e. not being treated in a bed on the inpatient service local to them).
- Approximately one in four patients (27%) were inappropriately placed in acute inpatient care.
- Approximately one in every five patients (23%) were considered medically well enough to be discharged from the ward but prevented from this happening due to another factor.
- Approximately one in ten patients (8%) had been previously admitted to their current or another inpatient unit in the 30 days prior to the current admission.
- The involvement of a psychiatrist at the point of admission may have prevented one in ten admissions (10%).
- Approximately nine out of ten respondents (92%) said that patients on their wards generally received care in line with NICE Guidelines.
- Respondents identified improved access to psychological services, supported housing and personality disorder services as being the most important developments needed along the acute care pathway.

Box 2.2: Survey methodology

The Commission surveyed acute psychiatric wards in Northern Ireland between Wednesday 20th April and Friday 6th May 2016. Psychiatric Intensive Care Unit (PICU) wards and older adult psychiatric wards were excluded, except in cases where wards provided mixed provision with acute beds and PICU/older adult psychiatric beds. Responses were received from 16 acute psychiatric wards, representing 100% of acute psychiatric wards in the Region. Twelve of the responses were fully completed and four responses were partially completed. As part of the survey responses, non-identifiable patient level data was collected on 219 patients.

Questions for the survey were designed by the Commission team based on guidance provided by a consultant who worked with the Commission. Trainee psychiatrists were identified in each of the five Trusts, who facilitated the data collection and collaborated with each ward's lead consultant to complete the survey questions. If more than one consultant worked on the ward, the trainees worked with both consultants to complete the survey.

The results of the survey reveal that there are serious problems in how the whole system is working in Northern Ireland with many patients not being cared for in the most appropriate settings. The majority of respondents to the survey (58%) stated that there were not sufficient acute psychiatric beds in their local area. The vast majority of patients were, however, receiving care according to NICE guidelines in the opinion of the respondents completing the survey.

Patients in the wrong place or experiencing delayed discharges

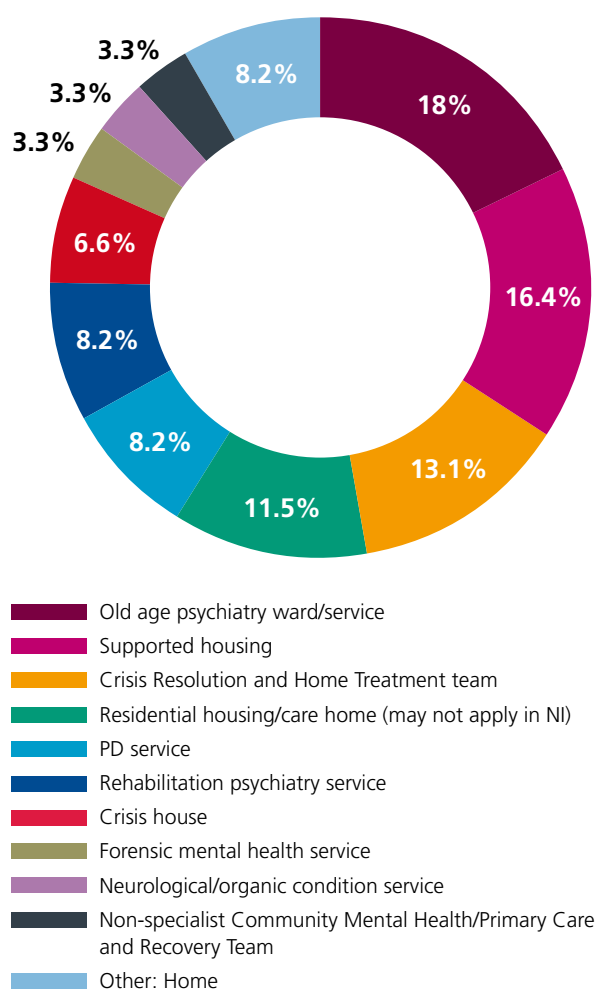
Two of the most significant findings were that one in four patients were inappropriately placed and one in five were ready for discharge. These findings are discussed in more detail below.

Inappropriate placementsⁱ

27% of patients (n=61) were not in the right setting to appropriately meet their needs at the time the survey was completed. On average there were five patients inappropriately placed on each ward representing around 25% of patients under the care of the ward.

For patients placed inappropriately, the top three more appropriate settings for them were identified as being older adult services, supported housing or CRHTs. Figure 2.3 lists where the patients identified as being inappropriately placed in acute inpatient care should, in the opinion of the respondents, have been treated instead.

Figure 2.3: Where patients might have been more appropriately treated



ⁱ For this question only, older adult "overspill" patients who were being treated on acute wards were included in the count, meaning data for 228 patients was included.

The survey results largely tally with what the Commission heard about poor access to specialist care, alternatives to inpatient care and rehabilitation services. The Commission was told that due to its population size Northern Ireland does not have the full range of readily accessible specialist in-patient services. For example, deaf patients, requiring inpatient psychiatric treatment must travel to England to access beds. The consequences of the lack of specialised services are twofold. Firstly, patients requiring specialist treatment have to be treated on general acute adult wards less appropriate to their needs, and secondly, this then has the knock-on effect of increasing the pressures on acute inpatient units, as these patients take up beds that should be used for patients requiring an acute admission.

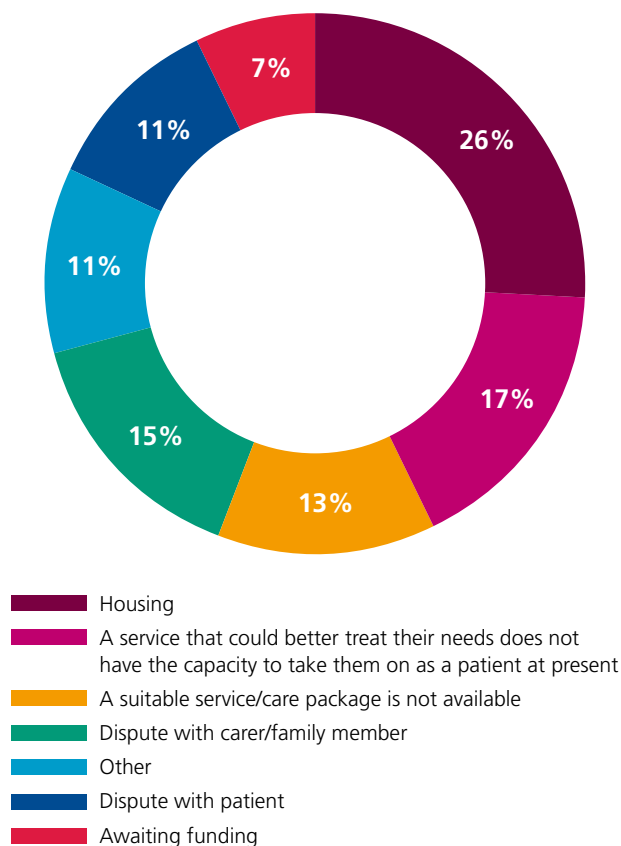
Delayed discharge

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. Delayed discharges not only mean that a bed is being unnecessarily occupied (thus rendering it unavailable to a patient who could benefit from it), but can also increase risks for the patient concerned either in terms of their clinical outcomes or potential institutionalisation.

Twenty-three per cent of patients (n=50) in the survey were considered medically well enough to be discharged from the ward but could not be due to other factors. On average there were four delayed patients on each ward.

Valid data on length of delay was recorded for 46 patients. For these patients the median length of delay was 14 days and 11 patients had been delayed for more than a month. The main causes identified for delayed discharges are listed in Figure 2.4. The most common factors were housing (18%), followed by a service that could better treat their need not having the capacity to take them on as a patient (17%).

Figure 2.4: Reasons for delayed dischargeⁱⁱ



ⁱⁱ For this question only, older adult “overspill” patients who were being treated on acute wards were included in the count, meaning data for 228 patients was included.

Table 2.1: Service developments required along the acute care pathway

Service development	% of responses that mentioned this service development
Access to personality disorder services	33%
Access to rehabilitation services	33%
Access to supported accommodation	33%
Access to ward psychology	33%
Increased availability/ capacity in CRHT	17%
Access to dual diagnosis services	17%
Increased psycho/social support in the community	17%
Access to housing	17%
Access to a day hospital	8%
Increased CMHT in-reach	8%
Increased number of acute beds	8%
Access to pre-senile dementia service	8%
Improved care management	8%
Increased reflective group practice for MDT	8%
Access to hostels	8%
Improved information sharing	8%

Service developments required along the acute care pathway

Twelve respondents identified service developments that they thought were needed along the acute care pathway. These are shown in Table 2.1.

The analysis of the service developments that are needed places access to personality disorder services, rehabilitation services, supported housing and psychology services at the top of the priorities. This is entirely consistent with the discussions the Commission had with people from all backgrounds in Northern Ireland and represents a priority list for future development and investment.

Personality disorder services

The Commission's survey showed that of those inpatients who were in the wrong place, approximately one in ten (8%) should have been placed in a personality disorder service.

The Bamford Review recommended the development of specialist personality disorder services in Northern Ireland.⁸ Following consultation, the DHSSPS published a strategy entitled *Personality Disorder: A Diagnosis for Inclusion, outlining a strategy for the enhancement of Personality Disorder services in Northern Ireland*.⁹ A subsequent Regional Care Pathway for Personality Disorders guideline

published by the Health and Social Care Board in 2014 acknowledged that although the 2010 strategy was “only partially funded” because of the 2008 economic downturn, “nonetheless, all five Health and Social Care Trusts (including within Prison Health) currently have community based services for people with Borderline Personality Disorder, guidance, and evidence based interventions.”¹⁰ The Queen's University Belfast *Regress? React? Resolve?* report triangulates this, suggesting that there are indeed adequate community personality disorder services available.¹¹ However, the Commission was told by its Advisory Board and clinicians that access to both specialist inpatient and community services for personality disorder is still a problem.

Rehabilitation psychiatry services

The Commission's survey found that 8% of the inappropriately placed inpatients should have been treated in a rehabilitation psychiatry setting. The Commission has also heard from multiple sources that there is an under-provision of community and inpatient rehabilitation services. The almost complete absence of dedicated rehabilitation services in Northern Ireland and the inadequate provision of community placements for those who require ongoing and, at times, flexible support, has a very significant effect on bed utilisation. This is due either to delayed discharges or to recurrent admissions into acute inpatient units of those who

would benefit from a longer period of rehabilitation, in either a specialist inpatient or a community facility.¹² These inappropriate admissions can mean that acute beds which could be used for other patients are unavailable.

It has been suggested that meeting the goal of ending long-stay institutional care in Northern Ireland can only be achieved if there is an adequate rehabilitation psychiatry pathway to enable recovery for people with the most severe and complex illness.¹³

Rehabilitation psychiatry services are effective and can save costs.¹⁴ In a study in the Republic of Ireland, a group of service users accessing a rehabilitation service was compared with a group with similar problems waiting for the same service. The rehabilitation group was eight times more likely to achieve and sustain successful community living.¹⁵

A spectrum of rehabilitation services is required, ranging from community services to high dependency inpatient units and 'low secure' units. Guidance from the Joint Commissioning Panel on Mental Health sets out the format of these services and the number of units required per head of population. Each unit should have approximately 14 beds. The number of beds per population is summarised below:¹⁶

- *Low secure rehabilitation units – one unit is needed for a population over 1 million*
- *High dependency inpatient rehabilitation units – one unit is needed for a population of 600,000 to 1 million*
- *Community rehabilitation units – one unit is needed for a population of around 300,000*
- *Longer term complex care units – one unit is needed for a population of around 600,000*

On the basis of these figures, there is a clear need for the development of rehabilitation psychiatry services in Northern Ireland commissioned at both the Trust and the Regional level.

Access to psychological services

One of the key areas that came up time and again was the problems of accessing psychological services of all kinds and this appears to be a key issue for service delivery. The Commission's survey found that access to psychological services was a key barrier to delivering NICE concordant care on wards and one third of respondents identified access to psychological services as a key development needed along the acute care pathway.

Northern Ireland does not have a comparable programme to the English Improving Access to Psychological Therapies (IAPT) initiative, which is thought to have paid for itself through enabling people to return to work.¹⁷

The DHSSPS published the *Strategy for the Development of Psychological Therapy Services* in 2010. This made 14 recommendations to improve access to psychological therapy services across the spectrum of severity of illness. The foremost recommendation was that:

*"The provision of psychological therapies should be a core component of mental health and learning disability services. Services should be delivered by staff with the skills and competence appropriate to the level of interventions required, and to national and regionally agreed standards and guidelines."*¹⁸

Unfortunately, it appears that progress has been limited. In 2013 the Regulation and Quality Improvement Authority (RQIA) examined a sample of patients in each Trust who had committed suicide, in order to assess how much psychological input they had received. Fifteen per cent of the files they reviewed mentioned referral to Clinical Psychology/Psychological Therapy services, and 38% of the files indicated that individuals were advised to contact third sector organisations for psychological support.¹⁹ The Commission notes with particular concern that *"referrals seem[ed] to be made on the basis of individuals getting generic supportive counselling, as opposed to matching the psychological presentation to the relevant evidence-based intervention."*²⁰ The RQIA concluded that *"despite the growing evidence base, professional guidelines, local and national strategy, together with service-user preference for psychological interventions, there is very little evidence of improved access to psychological therapies. Medication appears to be the intervention of choice."*²¹

The 2013 study precipitated a broader investigation by the RQIA into the psychological therapies available to people in inpatient settings, which was completed in 2015. Their report highlighted extreme variation across Trusts. At one end of the scale patients had access to dedicated, high-quality services whereas at the other some patients simply did not receive any NICE recommended psychological therapies. Only one Trust – the Belfast Health and Social Care Trust – had a dedicated clinical psychology and psychological therapies service for inpatients. The Northern and South Eastern Trusts both had limited access to psychological services although this was restricted to exceptional circumstances, such as when assessment or intervention was critical to patient care.²² The Commission

noted the RQIA's assessment that in many services *"the general opinion was that there was no point in even trying to access psychology, with some senior long term staff reporting they had never seen a psychologist on the ward."*²³ Improved access to psychological services could improve clinical outcomes for both mental and physical health conditions, with the potential for significant cost savings.²⁴

The Commission supports the RQIA's recommendations that *"in keeping with the DHSSPS 'Strategy for the Development of Psychological Therapy Services' (2010) it is recommended that evidence-based low and high intensity psychological interventions should be available to all patients in acute mental health wards. A mapping of therapeutic skills, across wards should be conducted to identify existing knowledge and skills as well as gaps in and hindrances to the delivery of therapeutic interventions."*²⁵ However, the Commission notes that this is virtually identical to the 2010 recommendation of the DHSSPS, and that progress in the intervening five years was unsatisfactory.

Supported accommodation

Supported accommodation services are a key component in a whole-system care pathway for people with mental health problems and can provide the basis for individuals to recover, receive support and in many cases return to work or education. Despite this, there have been concerns about the provision of supported housing in Northern Ireland, with one audit from 2012 finding no adequate supported housing initiatives in the whole Region. Voluntary sector providers also expressed frustration with the model for commissioning and funding the services. Concerns have also been raised around the delivery of the Supporting People fund, which uses the housing budget to fund supported community living. Delivering rehabilitation services within the restrictions of the scheme has proven challenging as the definitions of support cannot be flexibly applied and funding through housing benefit leaves service users with the unreasonable dilemma that, in order to access an essential treatment to aid their recovery, they have to give up their home.²⁶

The Commission's survey indicates that the provision of supported housing remains a concern with one third of respondents stating that supported accommodation is a key service development needed along the acute care pathway and around one in six of the patients inappropriately placed on acute wards identified as

needing a supported housing setting. The Commission was told that even in areas where the supply of supported housing was not so much of an issue, problems still arose from a 'one size fits all' approach, which is inflexible to different levels of need.

Crisis Resolution and Home Treatment teams

The survey confirmed that there is a capacity problem for CRHTs as they were identified as being the appropriate setting for 13% of the inappropriately placed inpatients. The Commission was told by members of its Service User and Carer Advisory Group about inappropriately long waiting times to access crisis care, with services effectively focusing on crisis management rather than crisis prevention. CRHTs have begun to emerge over the past three years, although the Commission heard they have been criticised for the variation in the services they offer (e.g. opening times) and the need for more patient/carer involvement. The RCPsych in Northern Ireland told the Commission that Home Treatment Teams have been successful in treating those with acute psychiatric illness in the community, but less so in managing patients who present with high risk in the absence of mental illness. They added that it is this group of patients who are often admitted voluntarily or detained for crisis management and to establish whether they have a mental illness.

In addition to the services which were described as needing development in the survey the Commission was told of other services that are needed. Four are discussed briefly below.

Perinatal services

The virtual non-existence of perinatal services (which treat mental illnesses which occur during pregnancy and the initial postpartum year, including mental health problems that arise during this period and also those that were present before the start of the pregnancy) was raised with the Commission as a matter of significant concern. Although the survey did not point to problems with access to specialist perinatal psychiatry services, this is likely to reflect its 'snapshot' nature, providing a picture of a particular ten-day period in April-May 2016. The Commission understands that each year in Northern Ireland approximately 70 women require inpatient admission during the perinatal period, and that the lack of appropriate perinatal services is *"endangering lives"*.²⁷ Current NICE guidance recommends that women who require inpatient treatment for any mental health problem in the perinatal

period should be admitted to a Mother and Baby Unit,²⁸ yet there is no such inpatient service available in Northern Ireland and only one community service.²⁹

The Commission understands that a service in Scotland which serves a roughly equivalent population to Northern Ireland – the West of Scotland Mother and Baby Unit – provides six inpatient beds to manage 50 admissions a year.³⁰ This suggests that approximately nine beds would be required to manage the level of need in Northern Ireland. Extrapolating from the Centre for Mental Health's 2014 report *The Costs of Perinatal Mental Health Problems* which used Department of Health reference data for 2012/13, the cost of providing nine inpatient Perinatal beds can be estimated at around £1.11m (in 2012/13 prices).³¹

An inpatient service would also provide a 'hub' function to support community perinatal 'spoke' services, a model used successfully elsewhere, which would also benefit from development.

Eating Disorder services

The survey identified one patient who would have been more appropriately treated in an inpatient Eating Disorder unit. This does not necessarily reflect a lack of need, and concerns about this prompted a review of Eating Disorder services in 2015 by the RQIA.³²

Northern Ireland does not have a dedicated inpatient Eating Disorder service. Children and adolescents are admitted to a general CAMHS service. Between 1 April 2011 and 31 March 2015 a total of 83 young people were admitted for treatment of eating disorders to this service, and admission rates more than doubled from 12 in 2011-12 to 26 in 2014-15. Many adults (and, in rare cases, children/adolescents) are sent abroad for care as 'Extra Contractual Referrals' (which are discussed more broadly in Chapter Five). Table 2.2 sets out the number of Extra Contractual Referrals relating to Eating Disorders between 2012/13 – 2014/15 and their in-year cost.

The RQIA report noted that "trusts indicated their capacity to respond to referrals for eating disorder services is proving a challenge in terms of meeting existing needs. Without additional investment in eating disorder services trusts consider the current capacity to respond to assessed needs will be diminished, resulting in continued delays for patients in accessing treatment. The review team did not find evidence of any evaluation carried out by the [Health and Social Care] Board of the effectiveness and value for money of ECRs."³⁴

Table 2.2: Number and cost of Extra Contractual Referrals relating to Eating Disorders 2012/13-2014/15³³

	2012/13	2013/14	2014/15
Adults	9	11	15
Children	0	1	2
Cost/m	£1.23	£1.38	£1.64

Guidance published by the Eating Disorders Faculty of the Royal College of Psychiatrists suggests that six beds (or a combination of fewer beds and intensive day care places) per 1 million population, together with two or three local outpatient clinics, should be provided for patients over 16 years of age.³⁵ Extrapolation to Northern Ireland would suggest that approximately 11 beds would be required for the Region.

Neuropsychiatric services

Although the survey did not suggest that many patients on the acute wards surveyed could have been more appropriately treated in neuropsychiatric services at that point in time, the Commission was told by a senior clinician in this field that both community and inpatient services specialising in this area are needed. Based on provision in Scotland, they estimated that six neuropsychiatry inpatient beds are required.

Access to Old Age Psychiatry services

Five of the acute wards (31%) reported an overspill of older adult patients waiting for beds to become available on older adult wards. Although these patients are likely to be older adults with functional illnesses, such as depression, rather than dementia patients, these findings raise questions as to whether there are sufficient beds for elderly patients with functional mental illness in the Region and the Commission proposes that this finding is explored further.

Box 2.3: The Regional Bed Management Protocol⁴⁰

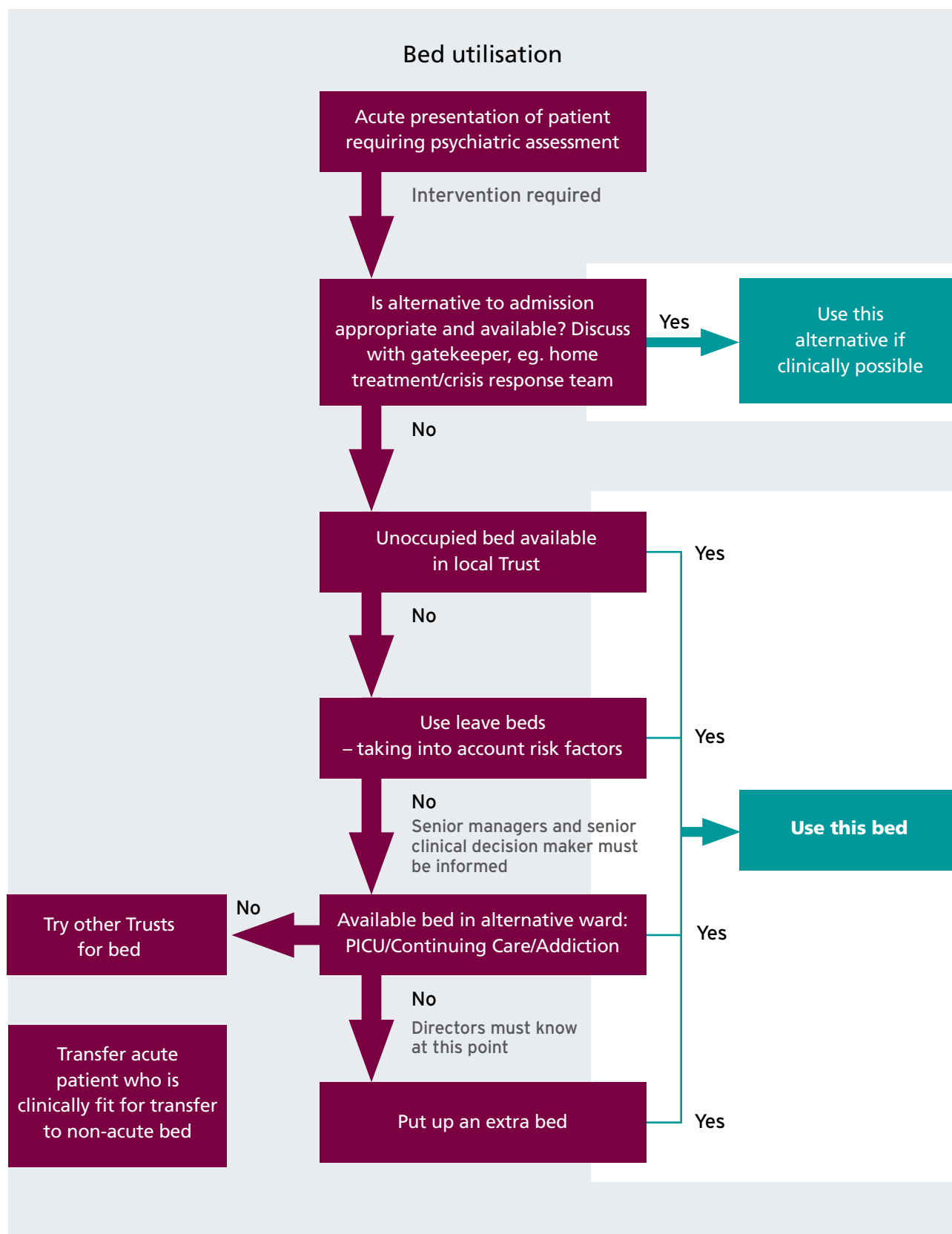


Table 2.3: Barriers to appropriate placement

Barrier	Number of times mentioned	% of patients for which this factor was relevant
Appropriate service is not available locally	28	43%
Waiting for a space at appropriate service	18	30%
Application for appropriate service is ongoing	4	7%
Disagreement with family over appropriate setting	4	7%
Assessment for appropriate service ongoing	2	3%
Other	4	7%
Dispute with patient over appropriate setting	3	5%

System problems: barriers to being placed in an appropriate service

The survey's respondents were asked to describe the barriers to patients being placed in the correct setting. Results are presented in Table 2.3. The salient problem was clearly capacity, either because the appropriate service was not available locally at all (43%), or if there was a local service there was a wait for a space to become available (30%). Looking at the responses in depth, it is again apparent that there are particular capacity issues relating to CRHTs, rehabilitation services, housing, older adult services and personality disorder services.

Out-of-area treatment

Out-of-area treatments cause clinical and practical problems for patients and for their families and carers. Geographical separation from a patient's support networks can leave them feeling isolated and delay recovery. Moreover, mental health personnel from the patients' home area have difficulties in visiting them with the result that they may spend longer as inpatients than they would have done if admitted locally. The association between out-of-area admissions and heightened suicide risk recently led the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness to call for an end to this practice.³⁶ Although this was based on English data, the Commission believes that this recommendation is directly applicable to Northern Ireland.

The Commission was told that the current Regional Bed Management Protocol (used by Trust bed managers and described in Box 2.3) is largely effective. This is currently being revised, and the Commission welcomes the fact that extra emphasis will be placed on the risks associated with out-of-area treatment in light of the findings of the 2015

National Confidential Inquiry on Suicide and Homicide by People with Mental Illness.³⁷ The updated Protocol makes it clear that acute out of area admissions should end.³⁸

However, the survey found that 15% of patients (n=32) surveyed were not being treated in their local acute inpatient unit and that in the majority of cases (81%) this was due to a shortage of acute adult beds in their local area.

There are a number of different factors which can create barriers to appropriate admissions or which are the direct consequence of these problems. Some of these are described briefly below.

High ward occupancy rates

Average ward occupancy was 95% (excluding patients on leave) and 101% (including patients on leave). Occupancy on the wards ranged from 73%–100% (excluding patients on leave) and 80%–115% (including patients on leave).ⁱⁱⁱ

Higher ward occupancy levels have frequently been associated with increased levels of aggression and violent incidents^{39,40,41,42} as well as with increased antidepressant use in healthcare staff.⁴³ Very high occupancy levels also clearly present a problem if an urgent admission is required, meaning that a patient may have to travel away from their local area to find a ward that has the bed capacity to admit them.

ⁱⁱⁱ These figures include any older adult or PICU patients staying on the wards. These figures also include a small number of leave patients who were described as being on long term leave from the ward.

Use of leave beds

There were 12 instances of a patient on leave/on a medical ward being unable to return to a bed on the same ward because of new patients being admitted to the beds. However, the Commission notes with concern that two responses also mentioned that patients were sometimes afraid to take overnight leave in case they lost their bed, meaning that these figures may not give an accurate picture of the pressure on beds.

Repeat admissions

Eight per cent of patients (n=17) in the survey had been admitted to their current or another inpatient unit in the 30 days prior to the current admission (excluding the current admission). This could indicate that some patients are being prematurely discharged, or that community services are not managing discharged patients adequately.

Involvement of a psychiatrist in admission

Under former legislation in Northern Ireland – the Mental Health (Northern Ireland) Order 1986 – a GP and approved social worker could admit a patient without having to liaise with a psychiatrist. The Commission has been told that this can result in patients being inappropriately admitted at the expense of patients who should be admitted (especially out-of-hours).

The Commission's survey reviewed psychiatrist involvement in 196 admissions to acute psychiatric wards and found that there 19 instances where a psychiatrist's involvement may have prevented the admission (around 10%). Eight of the preventable admissions were of patients who were detained at the point of admission, with the remaining 11 preventable admissions relating to voluntary admissions. Significant changes to the Mental Health (Northern Ireland) Order 1986 were proposed by the Bamford Review of Mental Health in the 2007 report 'A Comprehensive Legal Framework for Mental Health and Learning Disability', notably to 'fuse' legislation governing the treatment of mental illness and the absence of mental capacity.⁴⁴ Legislation – The Mental Capacity Act – has recently been passed to this effect, with the intention to "reduce the stigma associated with having separate mental health legislation and provide an opportunity to enhance protections for persons who lack capacity and are unable to make a specific decision in relation to their health (mental or physical), welfare or finances for themselves, including those subject to the criminal justice system."⁴⁵

The new legislation requires the involvement of at least one 'medical practitioner' before a person could be detained. The legislation does not specify that this medical practitioner should be a psychiatrist.

The Commission suggests that both any accompanying code of practice to the legislation and Trust policies recommend that a psychiatrist should be involved in the admission decision both for voluntary and involuntary patients.

Capacity assessment and improvement review

The discussion in this chapter illustrates very well the difficulties involved in managing across boundaries and ensuring that the whole system operates effectively. It also points to the need to get the right balance between services – whether this is between admission and CRHTs or acute services and specialist ones.

The Commission was asked specifically to describe the decision-making processes and criteria that can most effectively be used to determine the size and scope of the inpatient service and the number of beds required to deliver safe and therapeutic care in a given area.

There are many factors that influence the size and scope of inpatient services – ranging from population need to clinical practice, the availability of services provided by many different organisations, each provider's own operational policies and capabilities and their relationship with others – and one size, or one formula, can't fit all. Moreover each of these factors will change over time. The Commission has therefore set out an approach to determining the number of beds needed in an area which is dynamic and can be tailored to any area. It will allow providers both to ensure that they have an appropriately sized inpatient service at any time and to respond appropriately as circumstances change.

The approach proposed in this report is very much the same service capacity and improvement review as has been used by a number of mental health Trusts in England to make improvements and which is regularly used to reduce waiting times and make other improvements in services for physical health. The Commission recommends using a formal quality improvement approach in consultation with patients and carers groups to:

Box 2.4: Redesign of the care pathway and services by Southern Health and Social Care Trust

The Trust was aware of increasing pressure on acute beds. Limited Liaison Psychiatry cover for two Emergency Departments was identified as a key factor.

The Trust redeveloped its Out-of-Hours cover to ensure a prompt response to the Emergency Departments whilst also expanding the Home Treatment Team to provide a full 24 hour service. The Home Treatment Team improves access to home-based care for those with serious mental illness and those in crisis, working to prevent hospital admission throughout the 24 hour period. The emphasis is on prompt assessment to ensure patient flow through the Emergency Department, preventing patients with mental illness having to wait for long periods.

The 24 hour service has proved to be highly effective as well as reducing Emergency Department waiting times, it has reduced the number of admissions to both acute psychiatric beds and acute physical healthcare beds. The expanded service has the added benefit of promoting engagement with carers and facilitating patient choice, and the prompt assessment offered also means that clinical risk is better managed.

- 1 Establish the base line for demand, identifying peaks and troughs, and introduce processes for continual measurement of demand and capacity.
- 2 Introduce interventions designed to reduce demand or increase capacity. These might, for example, include strengthening CRHTs, adding more beds on a temporary or permanent basis, adding specialist services including psychology, auditing whether the care received by patients is concordant with NICE guidelines, improving bed management or reducing delayed discharges.
- 3 Study the result of the individual interventions, ensuring that the negative effects of any interventions are captured in the measurement system.
- 4 Make adjustments as necessary.
- 5 Embed effective interventions into standard work and normal practice.

There are many interventions that might be tried at stage 2 of this process to improve capacity and/or reduce demand for inpatient admission and in using this approach Trusts will want to employ the ones most likely to be effective. This can be determined from past experience, from evaluations and research or from modelling different scenarios using real data. Box 2.4 describes how Southern Health and Social Care Trust set about improving its acute care pathway and altered the balance between different parts of the service.

This chapter has described the general fragmented nature of the mental health system and the shortage of some essential services. This leads too often to poor quality care and wasted expenditure. Much is being done to tackle this but much more needs to be done both Regionally and through innovation and development locally. The following recommendation is designed to help improve the situation – through strengthening the functioning of the system itself and providing vital services.

The need for the development of community and specialised services is discussed further in Chapter Five which deals with funding and commissioning.

The Commission recommends that:

3. Improved functioning of the whole system.

Planners and providers need to work together across the Region to undertake a service capacity assessment and improvement review to ensure there are effective systems and sufficient capacity in different types of services (potentially including new specialist services) to enable patients to be cared for in the most appropriate setting.

References

- ¹ World Health Organization (2009). *Systems Thinking for Health Systems Strengthening*. Available at: http://apps.who.int/iris/bitstream/10665/44204/1/9789241563895_eng.pdf [Accessed 7 December 2015].
- ² Plsek PE., & Greenhalgh T. (2001). The challenge of complexity in health care. *BMJ*; 323 (7313):625-628.
- ³ Health and Social Care Board (2014). *You in Mind Regional Mental Health Care Pathway*. Belfast: Health and Social Care Board Available at: www.hscboard.hscni.net/mentalhealth/Regional_Care_Pathway_Mental_Health.pdf [Accessed 31 May 2016]
- ⁴ Bamford Review of Mental Health and Learning Disability (2005). *A Strategic Framework for Adult Mental Health Services*, p53. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf> [Accessed 11 May 2016]
- ⁵ The Commission on Acute Adult Psychiatric Care (2015). *Interim Report: Improving Acute Adult Psychiatric Care for Adults in England*, p7. Available at: http://media.wix.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf [Accessed 31 May 2016]
- ⁶ Bamford Review of Mental Health and Learning Disability (2005). *A Strategic Framework for Adult Mental Health Services*, p29. Belfast: Department of Health, Social Services, and Public Safety Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf> [Accessed 11 May 2016]
- ⁷ The Commission on Acute Adult Psychiatric Care (2015). *Interim Report: Improving Acute Adult Psychiatric Care for Adults in England*, p7. Available at: http://media.wix.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf [Access 31 May 2016]
- ⁸ Bamford Review of Mental Health and Learning Disability (2005). *A Strategic Framework for Adult Mental Health Services*. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf> [Accessed 11 May 2016]
- ⁹ Department of Health, Social Services and Public Safety (2010). *Personality Disorder: A Diagnosis for Inclusion. The Northern Ireland Personality Disorder Strategy*. Belfast: DHSSPS. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Northern-Ireland-Personality-Disorder-Strategy-June-2010.pdf> [Accessed 31 May 2016]
- ¹⁰ Health and Social Care Board (2014). *Regional Care Pathway for Personality Disorders: Promoting Hope, Opportunity and Personal Control*. Belfast: Health and Social Care Board. Available at: http://www.hscboard.hscni.net/mentalhealth/Regional_Care_Pathway_for_Personality_Disorder_PDF_1MB.pdf [Accessed 18 May 2016]
- ¹¹ Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. & Faulkner, L. (2015). *Regress? React? Resolve?: An evaluation of mental health service provision in Northern Ireland*. Available at: http://pure.qub.ac.uk/portal/files/17051927/Regress_React_Resolve.pdf [Accessed 17 May 2016]
- ¹² Royal College of Psychiatrists (2014). *Recovery for people with severe and complex mental health problems in Northern Ireland. A guide for trusts and commissioners of rehabilitation services*. Belfast: The Royal College of Psychiatrists. Available at: <http://www.rcpsych.ac.uk/files/pdfversion/CR187.pdf> [Accessed 31 May 2016]
- ¹³ Royal College of Psychiatrists (2014). *Recovery for people with severe and complex mental health problems in Northern Ireland. A guide for trusts and commissioners of rehabilitation services*. Belfast: The Royal College of Psychiatrists. Available at: <http://www.rcpsych.ac.uk/files/pdfversion/CR187.pdf> [Accessed 31 May 2016]
- ¹⁴ Joint Commissioning Panel for Mental Health (2012). *Guidance for commissioners of rehabilitation services for people with complex mental health needs*. Available at: <http://www.jcpmh.info/wp-content/uploads/jcpmh-rehab-guide.pdf> [Accessed 25 May 2016]
- ¹⁵ Lavelle, E., Ijaz, A., Killaspy, H. et al (2011). *Mental Health Rehabilitation and Recovery Services in Ireland: A Multicentre Study of Current Service Provision, Characteristics of Service Users and Outcomes for Those With and Without Access to These Services*. Mental Health Commission of Ireland Available at: http://www.mhcirl.ie/File/Dr_Ena_Lavelle.pdf [Accessed 1 June 2016]
- ¹⁶ Joint Commissioning Panel for Mental Health (2012). *Guidance for commissioners of rehabilitation services for people with complex mental health needs*. Available at: <http://www.jcpmh.info/wp-content/uploads/jcpmh-rehab-guide.pdf> [Accessed 25 May 2016]
- ¹⁷ The Centre for Economic Performance's Mental Health Policy Group (2012). *How Mental Health Loses Out in the NHS*. London: LSE. Available at: <http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf> [Accessed 25 May 2016]
- ¹⁸ Department of Health, Social Services and Public Safety (2010). *A Strategy for the Development of Psychological Therapy Services*, p7. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/strategy-development-psychological-therapy-service.pdf> [Accessed 29 January 2016]
- ¹⁹ The Regulation and Quality Improvement Authority (2013). *Access to Evidence Based Psychological Therapies for Adults who Subsequently Complete Suicide*. Belfast: The Regulation and Quality Improvement Authority. Available at: http://www.rqia.org.uk/cms_resources/Review_of_access_to_PTs_Suicide_December_2013.pdf [Accessed 29 January 2016]
- ²⁰ The Regulation and Quality Improvement Authority (2013). *Access to Evidence Based Psychological Therapies for Adults who Subsequently Complete Suicide*, p19. Belfast: The Regulation and Quality Improvement Authority. Available at: http://www.rqia.org.uk/cms_resources/Review_of_access_to_PTs_Suicide_December_2013.pdf [Accessed 29 January 2016]

- ²¹ The Regulation and Quality Improvement Authority (2013). *Access to Evidence Based Psychological Therapies for Adults who Subsequently Complete Suicide*, p21. Belfast: The Regulation and Quality Improvement Authority. Available at: http://www.rqia.org.uk/cms_resources/Review_of_access_to_PTs_Suicide_December_2013.pdf [Accessed 29 January 2016]
- ²² The Regulation and Quality Improvement Authority (2015). *A Review of Acute Mental Health Inpatient Access to Psychological Interventions and Therapies 2014/15*. Belfast: The Regulation and Quality Improvement Authority. Available at: http://www.rqia.org.uk/cms_resources/Access%20to%20Psychological%20Interventions%20and%20Therapies.pdf [Accessed 29 January 2016]
- ²³ The Regulation and Quality Improvement Authority (2015). *A Review of Acute Mental Health Inpatient Access to Psychological Interventions and Therapies 2014/15*, p5. Belfast: The Regulation and Quality Improvement Authority. Available at: http://www.rqia.org.uk/cms_resources/Access%20to%20Psychological%20Interventions%20and%20Therapies.pdf [Accessed 29 January 2016]
- ²⁴ The Regulation and Quality Improvement Authority (2015). *A Review of Acute Mental Health Inpatient Access to Psychological Interventions and Therapies 2014/15*. Belfast: The Regulation and Quality Improvement Authority. Available at: http://www.rqia.org.uk/cms_resources/Access%20to%20Psychological%20Interventions%20and%20Therapies.pdf [Accessed 29 January 2016]
- ²⁵ The Regulation and Quality Improvement Authority (2015). *A Review of Acute Mental Health Inpatient Access to Psychological Interventions and Therapies 2014/15*, p8. Belfast: The Regulation and Quality Improvement Authority. Available at: http://www.rqia.org.uk/cms_resources/Access%20to%20Psychological%20Interventions%20and%20Therapies.pdf [Accessed 29 January 2016]
- ²⁶ Royal College of Psychiatrists (2014). *Recovery for people with severe and complex mental health problems in Northern Ireland. A guide for trusts and commissioners of rehabilitation services*. Belfast: The Royal College of Psychiatrists. Available at: <http://www.rcpsych.ac.uk/files/pdfversion/CR187.pdf> [Accessed 31 May 2016]
- ²⁷ BBC News (2016). *Lack of perinatal services 'endangering lives'*. Available at: <http://www.bbc.co.uk/news/uk-northern-ireland-35652441> [Accessed 25 May 2016]
- ²⁸ National Institute for Health and Care Excellence (2015). *Antenatal and postnatal mental health: clinical management and service guidance NICE guidelines [CG192]*. Available at: <https://www.nice.org.uk/guidance/CG192> [Accessed 31 May 2016]
- ²⁹ Maternal Mental Health Alliance (2015). *Map of Perinatal Provision*. Available at: http://everyonesbusiness.org.uk/wp-content/uploads/2015/12/UK-Specialist-Community-Perinatal-Mental-Health-Teams-current-provision_2015.pdf [Accessed 25 May 2016]
- ³⁰ NHS Greater Glasgow and Clyde (n.d). *Perinatal Mental Health Service and West of Scotland Mother & Baby Unit*. Available at: <http://www.nhsggc.org.uk/your-health/health-services/mental-health-services/services/other-services/west-of-scotland-mother-baby-unit/> [Accessed 25 May 2016]
- ³¹ Bauer, A., Parsonage, M., Knapp, M., Lemmi, V. & Adelaja, B. (2014). *The Costs of Perinatal Mental Health Problems*. LSE PSSRU/Centre for Mental Health. Available at: <http://everyonesbusiness.org.uk/wp-content/uploads/2014/12/Embargoed-20th-Oct-Final-Economic-Report-costs-of-perinatal-mental-health-problems.pdf> [Accessed 31 May 2016]
- ³² The Regulation, Quality and Improvement Authority (2015). *Review of Eating Disorder Services in Northern Ireland*. Belfast: The Regulation and Quality Improvement Authority. Available at http://www.rqia.org.uk/cms_resources/Eating_Disorder_Review_Final_18_Dec_15.pdf [Accessed 25 May 2016]
- ³³ The Regulation, Quality and Improvement Authority (2015). *Review of Eating Disorder Services in Northern Ireland*. Belfast: The Regulation and Quality Improvement Authority. Available at http://www.rqia.org.uk/cms_resources/Eating_Disorder_Review_Final_18_Dec_15.pdf [Accessed 25 May 2016]
- ³⁴ The Regulation, Quality and Improvement Authority (2015). *Review of Eating Disorder Services in Northern Ireland*, p61. Belfast: The Regulation and Quality Improvement Authority. Available at http://www.rqia.org.uk/cms_resources/Eating_Disorder_Review_Final_18_Dec_15.pdf [Accessed 25 May 2016]
- ³⁵ The Royal College of Psychiatrists (2000). *Eating Disorders in the UK: Policies for Service Development and Training (Council Report 87)*. London: The Royal College of Psychiatrists. Available at: <http://www.rcpsych.ac.uk/files/pdfversion/CR170.pdf> [Accessed 25 May 2016]
- ³⁶ The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2015). *Annual Report: England, Northern Ireland, Scotland and Wales*, p11. Available at: www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked.pdf [Accessed 1 December 2015].
- ³⁷ The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2015). *Annual Report: England, Northern Ireland, Scotland and Wales*, p11. Available at: www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked.pdf [Accessed 1 December 2015].
- ³⁸ Health and Social Care Board (2015). *Regional Bed Management Protocol For Acute Psychiatric Beds*. Belfast: Health and Social Care Board [Internal document supplied to the Commission]
- ³⁹ Teitelbaum, A., Lahad, A., Calfon, N., Gun-Usishkin, M. & Lubin, G., Tsur, A. (2016). Overcrowding in Psychiatric Wards is Associated With Increased Risk of Adverse Incidents. *Med Care*. 54(3):296-302

- ⁴⁰ Ng, B., Kumar, S., Ranclaud, M. & Robinson, E. (2001). Ward crowding and incidents of violence on an acute psychiatric inpatient unit. *Psychiatr Serv.* 52(4):521-5.
- ⁴¹ Virtanen, M., Vahtera, J., Batty, G.D., Tuisku, K., Pentti, J., Oksanen, T., Salo, P., Ahola, K. & Kivimäki, M. (2011). Overcrowding in psychiatric wards and physical assaults on staff: data-linked longitudinal study. *Br J Psychiatry.* 198(2):149-55.
- ⁴² Nijman, H.L. & Rector, G. (1999). Crowding and aggression on inpatient psychiatric wards. *Psychiatr Serv.* 50(6):830-1.
- ⁴³ Virtanen, M., Pentti, J., Vahtera, J., Ferrie, J.E., Stansfeld, S.A., Helenius, H., Elovainio, M., Honkonen, T., Terho, K., Oksanen, T. & Kivimäki, M. (2008). Overcrowding in hospital wards as a predictor of antidepressant treatment among hospital staff. *Am J Psychiatry.* 165(11):1482-6
- ⁴⁴ The Bamford Review of Mental Health and Learning Disability (2007). *A Comprehensive Legislative Framework*, p2. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/legal-issue-comprehensive-framework.pdf> [Accessed 11 May 2016]
- ⁴⁵ Department of Health, Social Services and Public Safety (2014). *Draft Mental Capacity Bill (NI) Consultation Document*, p2. Belfast: Department of Health, Social Services, and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/consultations/dhssps/mental-capacity-consultation-document.pdf> [Accessed 11 May 2016]

03

Quality

Summary

A great deal of attention is being paid to quality in mental health in Northern Ireland with several important initiatives underway.

This chapter describes a vision for what a good service looks like and reviews activity in terms of quality planning, quality control and quality improvement.

It recommends the continuation and strengthening of the current programme for developing the capability and capacity for quality improvement across the whole system and the establishment of a simple set of quality standards for acute adult wards.

Quality of care

Patients and carers reported a slightly higher level of satisfaction with care and services in Northern Ireland than in the other parts of the UK in a recent survey.¹ Moreover, there is considerable emphasis on quality in strategy and planning as the examples in this chapter show.

Patients and carers told the Commission that high quality services are those which listen to patients' and carers' experiences, are responsive to their needs and where there is regular and clear communication from staff. They also stressed the importance of collecting patient and carer perspectives when assessing the quality of a ward, as in their experience some services do not offer the support that they officially say they offer. They also emphasised the need for quick access to services when needed – a good quality service is useless if those who need it can't access it.

The Commission also heard complaints from patients and carers about the quality of inpatient care, as described in Chapter Four, where it failed to match up to the standards that patients and carers wanted. Some of these problems are undoubtedly connected with the increasing pressure on the system, which is resulting in increasing levels of acuity of illness amongst inpatients.

The Commission saw and heard of some very good examples of wards both in terms of their operation and physical environment but argues that there is a need to upgrade many wards – reviewing staffing levels and staff mix, making improvements in the physical environment, and increasing the involvement of patients and carers.

The vision of a good acute service

The Commission has taken as its starting point the vision of a good acute service drawn up by its working group on quality and shown in Box 3.1. This covers both Crisis Resolution and Home Treatment teams (CRHTs) and inpatient wards.

The working group concluded that standards for home treatment should broadly be the same as for inpatient care. In home treatment services continuity of care is hugely valued by patients and clinicians alike. Whilst it is often not practically possible for the same clinicians to look after an individual patient both in the community and when receiving inpatient care, clinicians can, however, work across ward and crisis services and, where possible, this should be facilitated. This avoids a ward being a silo, completely separated from the community. It enables the team to understand better the patient's home environment and thus facilitate a good discharge. Moreover, many of the skills required for home based treatment are the same as those for hospital based treatment.

Quality

Good quality in all its aspects does not just arise by itself but needs to be planned for and worked at. Health workers will not automatically treat their patients well and services will not become equitable, efficient or safe without systematic attention to detail. Dr Joseph Juran has identified three sets of processes for the total management of quality, often called the Juran Trilogy.²

- **Quality planning:** designing a new process, product, or service to meet established goals under operating conditions.
- **Quality control:** operating and when necessary correcting the process, product, or service so that it performs with optimal effectiveness and minimal unwanted variation.
- **Quality improvement:** devising ways to take an existing process, product, or service to unprecedented levels of performance.

Each of these three is important and is discussed briefly in the Northern Ireland context below.

Box 3.1: Vision of a good acute service

A good acute service is one which has:

- A philosophy of care which is holistic, person-centred, facilitates recovery and is underpinned by humanity, dignity and respect.
- Staff working in acute care services who regard 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 and recovery through a collaborative approach. Patients should expect their experiences to be validated and where possible understood.
- A thorough holistic assessment process which includes a full social, psychological and medical history. Individuals should not repeatedly be asked the same questions by a series of professionals. Instead, different professionals should collaborate on a thorough and detailed assessment, considering:
 - 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) and goals together with those of their carers and networks (as appropriate)
 - 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 use
 - Social circumstances
 - Safeguarding issues concerning children and vulnerable adults
 - Physical health needs as well as mental health needs.
- A care pathway understood by all professionals and easily explainable to patients and carers. This should deliver a full range of evidence-based biopsychosocial and physical interventions which focus on the patient's recovery. As far as possible, it should be co-produced by the healthcare staff and patient in order to reflect both professional expertise and the individual's ambitions about their recovery.
- Inpatient wards which are safe, 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. Ligature points and blind spots are unacceptable. 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.

Quality planning and policy

There has been a great deal of work undertaken to provide a good planning framework for health and social care in recent years. This section refers to two major pieces of work on health and social care generally before turning to mental health specific frameworks and standards.

The overall strategy for quality – *Quality 2020: A 10 year strategy to protect and improve quality in health and social care in Northern Ireland*³ – was published in 2011 and continues to shape the overall approach. Its main elements are described in Box 3.2. An essential part of this approach which the Commission very strongly supports is the drive to raise the level of understanding and competence in quality improvement among staff throughout the country. These methodologies can play a fundamental part in all public policy and improvements in public services.

More recently, the Donaldson Review was established to examine the arrangements for assuring and improving the quality of care in Northern Ireland, to assess their strengths and weaknesses and to make proposals to strengthen them. This made a small number of wide ranging recommendations about governance and other aspects of health and social care.⁴

Turning to mental health specifically, Service Frameworks for Mental Health and Well Being were published in 2011 and are currently being revised. The new frameworks will describe the standards of high quality care that, when delivered collectively, should contribute to improving the effectiveness (measured in clinical outcomes), safety and experience of care for individuals using mental health services in Northern Ireland. The driving force for the revised Service Framework is the need to identify clear and consistent standards, informed by evidence and policy, which will facilitate improved monitoring and accountability of mental health services in Northern Ireland.

The standards being developed will focus on patient experience of all aspects of their care. The Service Framework has been jointly developed by people with lived experience of mental health conditions, carers, and professionals involved in commissioning and providing mental health care in Northern Ireland. The draft Service Framework will become operational in 2016.

Quality control and standards

The Regulation and Quality Improvement Authority (RQIA) was established in 2003 and is the independent health and social care regulator in Northern Ireland. It has the responsibility for monitoring, inspecting and encouraging improvements in the quality of health and social care services. This involves ensuring that all services are accessible, well-managed and meet the required standards.⁵

Wards are assessed against three questions (see Box 3.3), with compliance levels expressed as being either “met”, “partially met” or “not met”.⁶ In the latest annual report of inspections (2014) wards were assessed against ten expectation statements and more than half of the wards inspected were fully compliant with five of these. The highest levels of non-compliance were with expectations around awareness and application of safeguarding procedures and procedures for the effective management, support, supervision and training of staff. High levels of seclusion and reactive strategies were also noted and a number of recommendations were made in relation to poor record keeping by staff.⁷

The Commission is aware that there is a plethora of standards available which have been published by a number of different bodies. Furthermore, many of these, including the Royal College of Psychiatrists’ own standards, are contained in very large and extensive documentation. Whilst it notes the importance of these – and the current work the College is doing with the British Standards Institute to update and streamline these⁸ – it considers there is a need for a short user-friendly statement of best-practice standards for adult acute inpatient wards agreed by all the relevant bodies. This statement should be promoted amongst staff, patients and carers providing opportunities for it to be understood and, where appropriate, tailored to local services. The Royal College of Psychiatrists is well-placed to lead this project, working in conjunction with the Department of Health, RQIA, patients and carers.

The Commission recommends that this statement and the Minimum Data Set for Mental Health described in Chapter Five should be aligned so that performance against the standards can be monitored and reported on through the existing arrangements.

Box 3.2: The main elements of Quality 2020

Design principles

Quality 2020 identifies a number of design principles that should inform planners and practitioners over the course of the strategy. The principles are that a high quality service should:

- Be holistic in nature.
- Focus on the needs of individuals, families and communities.
- Be accessible, responsive, integrated, flexible and innovative.
- Surmount real and perceived boundaries.
- Promote wellbeing and disease prevention and safeguard the vulnerable.
- Operate to high standards of safety, professionalism and accountability.
- Be informed by the active involvement of individuals, families and communities, Health and Social Care staff and voluntary and community sectors.
- Deliver value for money ensuring that all services are affordable, efficient and cost-effective.

Values

Quality 2020 also identifies the need to promote the following values:

- **Empowerment** – supporting people to take greater responsibility for their own health and social wellbeing, and putting people at the centre of service provision.
- **Involvement** – ensuring that service users, their carers, service providers and the wider public are meaningfully involved, and if necessary supported, at all stages in the design, delivery and review of services at an operational and a strategic level so that, as far as possible, services are personalised.
- **Respect** – showing respect for the dignity of all people who use the service, their carers and families and for all staff and practitioners involved in service delivery.
- **Partnership** – engaging collaboratively across all disciplines, sectors and specialisms in health and social care, including the voluntary and independent sectors, to ensure an integrated team-based approach, and working with people in their local communities.
- **Learning** – promoting excellence in service delivery that is founded on evidence-based best practice to achieve improvement and redress problems.
- **Community** – anchoring health and social care in a community context.
- **Continuity** – ensuring a co-ordinated and integrated approach to health and social care in all health and social care sectors, and ensuring continuity of care across the system.
- **Equity and equality** – fairness and consistency in service development and delivery.

Setting strategic goals

The strategy identifies five strategic goals to be achieved by 2020:

- 1 **Transforming the Culture** – Creating a new and dynamic culture that is even more willing to embrace change, innovation and new thinking that can contribute to a safer and more effective service. It will require strong leadership, widespread involvement and partnership-working by everyone.
- 2 **Strengthening the Workforce** – It is vital that every effort is made to equip the workforce with the skills and knowledge they will require to deliver the highest quality.
- 3 **Measuring the Improvement** – In order to confirm that improvement is taking place more reliable and accurate means to measure, value and report on quality improvement and outcomes will be needed.
- 4 **Raising the Standards** – The service requires a coherent framework of robust and meaningful standards against which performance can be assessed. Patients, carers and families should be involved in the development, monitoring and reviewing of standards.
- 5 **Integrating the Care** – Integrated care should cross all sectoral and professional boundaries to benefit patients, clients and families.

Box 3.3: RQIA inspection framework

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions, each underpinned by key standards for good care:

Is care safe?

- Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Is care compassionate?

- Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Is care effective?

- The right care, at the right time in the right place with the best outcome.

Quality improvement

As noted earlier, the Quality 2020 strategy promotes the engagement of clinicians and others in understanding and using the methodologies of quality improvement. There have also been a number of specific initiatives designed to improve care, one of which is described below.

Releasing Time to Care

/The Productive Ward approach

The Releasing Time to Care/The Productive Ward approach was introduced in Northern Ireland in September 2009 by a joint Public Health Agency (PHA)/ Health and Social Care Board (HSCB) Regional Implementation Project Board, facilitated through the Mental Health Service Improvement Managers Programme across acute mental health wards. Each Trust established a Project Group to develop a local project plan in line with 'Releasing Time to Care' processes, to oversee the implementation of the programme across all acute admission wards.

A Releasing Time to Care Implementation Review was carried out between November 2014-March 2015 to evaluate the current benefit / impact in relation to Releasing Time to Care through provision of evidence of improvement in the areas of safety, effectiveness, and efficiency of care and patient experience.

Preliminary findings from the Review note that there is clear evidence that the model is embedded in acute inpatient mental health wards across Trusts, with some excellent examples of best practice. For example, each ward has its own weekly patient forum which ensures that patients have a say about the running of the ward and to find ways to improve their experience. The Belfast Health and Social Care Trust go a step further, using a patient discharge questionnaire which offers feedback and evidence about experience of care. Each ward displays a Safety Cross which supports a safety culture on the wards, and is available for all to see. All Trusts use the Releasing Time to Care modules as a tool to induct new staff around the running of the ward. For a lot of the wards, the efficiency and safety of ward rounds have improved significantly in terms of efficiency and safety as a result of the Releasing Time to Care Ward Rounds module.

It is important to note however that the degree to which it has been embedded across acute inpatient mental health varies from Trust to Trust, site to site and in some cases, ward to ward. There are a number of factors associated with this finding including leadership, staff turnover, lack of protected time, staff motivation and the implementation model/approach used.⁹

There are several other good examples of quality improvement work underway in Trusts with Box 3.4 describing the approach to quality and patient safety in one Trust.

The Institute of Healthcare Improvement Triple Aim Framework

There are two pilots underway using the Institute of Healthcare Improvement (IHI) Triple Aim Framework – the simultaneous pursuit of better care for individuals, better health for populations, and lower per capita costs – to improve services and health outcomes for patients.

These pilots at East Belfast Integrated Care Partnership and South Eastern Health and Social Care Trust are also testing scale-up methods to understand how a whole population can be covered. Following evaluation this approach may be used across the whole service.

This chapter has described how Northern Ireland is moving to improve quality and ensure that quality improvement is understood by people throughout the country. The Commission's recommendation here is designed to help support this process and focus in particular on standards in acute adult wards.

Box 3.4: Quality Improvement in South Eastern Health and Social Care Trust

South Eastern Health and Social Care Trust (SEHSCT) made safety, quality and experience a corporate priority in 2011. This reflected its broader culture of inquiry and a quality improvement approach to address locally identified indicators of safety, quality and experience. To help realise this priority, the Trust set up a capability building programme in 2011 through which staff learn about Quality Improvement methodology and work on a live improvement project. As of October 2015, more than 250 staff had completed the programme and in excess of 70 projects had been undertaken. At the start of 2014, SEHSCT opened a Quality Improvement and Innovation Centre to build on a range of organisational initiatives that currently focus on ensuring patient/client safety, improving quality and testing patient experience on a Trust-wide basis.

After making safety, quality and experience a priority corporate objective, the Trust took steps to ensure that all its structures and activities were aligned with it and geared towards fostering a culture of continuous quality improvement.

A range of departments worked with frontline teams to help them develop improvement action plans and measure and monitor progress against the safety, quality and experience indicators they had identified. This allowed frontline staff to use local intelligence to identify relevant indicators and targets for improvement. Facilitation was provided to develop improvement plans based on continuous monitoring of data. Open clinics and workshops were put in place to support staff during their improvement journey.

A Safety and Quality Leadership Committee chaired by the Chief Executive was set up, and leadership walk-rounds began focusing on the safety, quality and experience priorities in each area. Every directorate is expected to align clinical audit activity with local quality indicators, while accountability and performance management reviews now include safety, quality and experience. Success is measured using indicators that are relevant to the service, staff and patients, not on clock-based targets developed elsewhere. The aim is to ensure that every arm of the organisation is playing its part in helping to deliver a safer and better service.

The individual projects undertaken by the participants have led to improvements in the safety, quality and experience of services.¹⁰

The Commission recommends that:

4. Quality improvement and standards for acute adult wards. The current work to develop the capacity and capability for quality improvement of people throughout the whole system needs to be strengthened – to ensure everyone is working with a common approach and methodology – and linked with the development of a single set of easy to understand and measurable quality standards for acute adult psychiatric wards.

References

- ¹ National Audit of Schizophrenia (2014). *Report of the second round of the National Audit of Schizophrenia (NAS2) 2014: Report for Northern Ireland*. Available at: <http://www.rcpsych.ac.uk/pdf/NAS2%20NI%20national%20report%20FINAL.pdf> [Accessed 22 April 2016]
- ² The Juran Institute. *The Juran Trilogy Model*. Available at: www.juran.com/elifeline/elifefiles/2009/09/Juran-Trilogy-Model.doc [Accessed 12 September 2015]
- ³ Department of Health, Social Security and Public Safety (2011). *Quality 2020: A 10-year strategy to protect and improve health and social care in Northern Ireland*. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/q2020-strategy.pdf> [Accessed 25 May 2016]
- ⁴ Donaldson, L., Rutter, P. & Henderson, M. (2014). *The Right Time, The Right Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland*. Available at: https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf [Accessed 25 May 2016]
- ⁵ Regulation and Quality Improvement Authority website. Available at: http://www.rqia.org.uk/about_us/index.cfm [Accessed 24 May 2016]
- ⁶ Regulation and Quality Improvement Authority website. *Inspections of Mental Health Hospitals and Mental Health Hospitals for People with a Learning Disability, Indicators for the Delivery of Safe, Effective and Compassionate Person Centred Service*. Available at: http://www.rqia.org.uk/cms_resources/Indicators%20for%20the%20Delivery%20of%20Safe%2C%20Effective%20and%20Compassionate%20Person%20Centred%20Service_.pdf [Accessed 24 May 2016]
- ⁷ Regulation and Quality Improvement Authority (2014). *Mental Health and Learning Disability Annual Report 1 April 2013–31 March 2014*. Available at: http://www.rqia.org.uk/cms_resources/MHLD%20Annual%20Report%20April%202013%20to%20March%202014.pdf [Accessed 24 May 2016]
- ⁸ For more information please see <http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqprojects/corestandardsproject.aspx> [Accessed 22 December 2015]
- ⁹ NHS Institute for Innovation and Improvement website. *The Productive Ward*. Available at: http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html [Accessed 06.06.16]
- ¹⁰ The Health Foundation (2015). *Building the foundations for improvement. How five UK trusts built quality improvement capability at scale within their organisations*. Available at: <http://www.health.org.uk/sites/default/files/BuildingTheFoundationsForImprovement.pdf> [Accessed 18 May 2016]

04

Patient and carer experience

Summary

The chapter considers patient and carer experience. It shows that there is a great deal of commitment to patient and carer engagement and involvement in Northern Ireland and good supporting policies.

However, the chapter also describes patients wanting more activities, better facilities, continuity of care, treatment plans, and an end to disproportionate police involvement in assessments/admissions. It also reports that carers want to be more involved in assessments and planning care, and their concerns listened to about patients being prematurely discharged into their care.

The chapter makes a recommendation about the need for greater engagement of patients and carers in the mental health system, particularly in terms of early carer involvement.

Patient experience

The Commission met with many patients and carers, heard from others via its Call for Evidence and was able to consider recent reports. Taken together, this evidence showed that Northern Ireland is leading the way in developing patient and carer engagement and improving their experience of the whole system. There is, however, much more to do.

Many patients praised their care, and this is borne out by data from the 2014 National Audit of Schizophrenia which indicated that the experience of patients in Northern Ireland was broadly positive: over 85% of patients in each Trust rated their care as either being 'fairly' or 'very' satisfying. This is slightly higher than the equivalent figures for England and Wales.¹

The Commission is aware of some excellent programmes underway to improve care, such as the ImROC initiative which is described in Box 4.1.

However, the Commission notes that there are other data sources which paint a different picture. A 2013 survey of patient experiences across all mental health services found that 45% of respondents felt 'stronger' as a result of the treatment that they had received in the preceding year, whereas 33% felt 'set back and frustrated' and 22% felt 'stressed and anxious'.³ This variation between samples suggests that a more systematic approach to gauging patient experience is required, and suggests that there are areas where care is not always as good as it should be.

Northern Ireland performed slightly less well than England and Wales in the National Audit of Schizophrenia in terms of providing information about medication, involving patients in the development of treatment plans and monitoring physical health. As in England and Wales, there is a deficit in the availability of psychological therapies, particularly family therapies.⁴

Some respondents to the Commission's Call for Evidence cited concerns about a lack of meaningful and therapeutic activities, occupational therapy and interventions being available for patients whilst in acute care.

Box 4.1: ImROC (Implementing Recovery through Organisational Change)²

The Implementing Recovery through Organisational Change (ImROC) programme is a new approach to helping people with mental health problems. In mental health, 'recovery' means the process through which people find ways to live meaningful lives, with or without the on-going symptoms of their condition. ImROC aims to change how the NHS and its partners operate so that they can focus more on helping those people with their recovery.

The current phase of ImROC is based on an annual membership scheme and a range of supporting consultancy packages and is open to all NHS funded mental health service providers and partners that want to become more recovery-focused. Through membership of a 'learning set network' services and their partners will join colleagues at a selection of themed workshops, an annual conference and on-line through a virtual e-recovery platform.

ImROC was introduced in Northern Ireland in 2013. Each Trust has a lead for implementing ImROC projects. The RCPsych's Northern Ireland Division told the Commission that ImROC (which was introduced across all Trusts) has been helpful in introducing a shared understanding across the Region of the principles of patient-centred care and recovery and helps Trusts to identify potential strengths and deficits in their services. However if the gains of this programme are to be optimised resources will need to be provided.

The physical environment

The Commission has heard that the quality of the physical environment of many inpatient services in Northern Ireland is inadequate and has seen examples first-hand. The physical environment of acute wards is important for both safety and therapeutic reasons. Studies have shown how poor design can slow recovery, and how good design can enhance it. Good hospital design has the potential to reduce staff stress and fatigue, increase effectiveness in delivering care, improve patient safety, reduce stress, improve outcomes and improve overall healthcare quality.⁵

The programme of replacement of the old 'County Asylum' facilities by six purpose built mental health hospitals is not yet complete, although it is certainly promising that providing new facilities for inpatient care is a key priority. The Commission is aware that two units have already been built, and that there are plans in place for the remaining four units to be built. These will provide separate wards for males and females and en-suite bathrooms for all patients. The new units have fewer beds, but higher staff-to-bed ratios so that therapeutic interventions can increase.

Continuity of care

Continuity of care is sometimes lacking. The 2015 Queen's University Belfast report *Regress? React? Resolve?* drew attention to some patients' concerns that their care was highly fragmented, resulting in breakdowns in communication and subsequent problems with accessing new services. The transition from inpatient to community care was highlighted as being particularly problematic.⁶

Patients value seeing the same staff. This means they don't have to repeat their history, and provides the opportunity for a therapeutic relationship to develop. The Commission encourages services to review whether they are providing patients with a good level of continuity of care, and to address deficiencies as appropriate.

Equality issues

The Commission has also heard concerns about the experiences of patients with protected characteristics receiving treatment on acute psychiatric wards and from mental health services in general. Several respondents to the Call for Evidence highlighted concerns around staff interactions with individuals with learning disabilities or autistic spectrum disorders and felt that their communication needs were not adequately considered. The Commission also heard that deaf patients still face many challenges accessing appropriate services, with one recent report concluding that access to health services for deaf patients needs to be improved and mandatory access standards implemented and enforced.⁷

Treatment plans

The Commission understands that there are serious issues with patient treatment plans. The RQIA have indicated that in an audit undertaken in 2013/14 of 132 treatment plans for patients detained for periods of over three months, 80 treatment plans failed to meet the required standards (61%).⁸ Additionally, information gathered by the 2014 National Audit of Schizophrenia revealed that Trusts in Northern Ireland performed significantly worse than English and Welsh Trusts in terms of having adequate care plans. This potentially reflects the absence of a system equivalent to the Care Programme Approach, which operates in England and Wales. The Commission concurs with the National Audit of Schizophrenia's recommendation that progress in improving this aspect of care needs to be fostered and monitored.⁹

Involvement of the police

The disproportionately frequent involvement of the police in the process of being detained was highlighted to the Commission. A 2010 audit of police involvement in mental health assessments found that the police were directly involved in 44% of assessments, the majority of which were completed in the person's own home. A number of issues associated with police involvement were identified, in particular that police involvement actually exacerbated tense situations.¹⁰ Although the Commission is pleased to note that there has been a slight decrease in this figure to 41%, with some evidence of improved practices,¹¹ there is clearly a long way to go.

The Law Centre NI told the Commission that it had heard concerns about the unnecessary involvement of the police in home assessments prior to admission, and the problematic consequences of this practice, such as:

*"In [my] view inpatient care begins at the moment the person is assessed at home prior to admission. Clients tell us that the healthcare professionals are frequently accompanied by uniformed Police Officers and marked police vehicles and ambulances. This practice is rarely necessary, causes distress to the individual and their family and increases the potential for stigma in the neighbourhood. The knock on effect is felt on the ward in behaviours which reflect the person's frustration."*¹²

Carer experience

The 2014 National Audit of Schizophrenia found that just over 80% of carers were satisfied or fairly satisfied with the support and information they have been provided in the previous 12 months. Carers in Northern Ireland were slightly more likely to report better support and involvement in decision making than those in England or Wales.

Similar to the results for England and Wales, the provision of information about prognosis was the worst area of deficiency for Northern Ireland.¹³

Involvement in care

Family members provide much and, often, most of the care for people with mental illnesses and it is essential that they are as involved as possible in the planning and delivery of care once this is shared with professional health care services. They can help professionals gain a better understanding of the individual, describe how the illness has affected them and provide an insight into how they will best benefit from treatment. Carers are often the first to recognise triggers and identify unusual behaviour patterns. They knew the person before they became unwell and can remind everyone of a person's individual characteristics so that they are not reduced to just a list of symptoms.

Carers identified problems with accessing services if the patient was 'not ill enough' to meet the threshold for admission, leading to a distressing period during which the patient's condition would deteriorate before getting to the point where admission was available as an option. This was further compounded by poor crisis care in some areas, leaving carers in great difficulty and coping with difficult situations themselves.

The Commission heard that carers want better information and support and good communication with services. In particular, they want to feel they can cope if and when a crisis develops and to learn appropriate coping strategies as well as what action they can take. One of the Commission's members, who is a carer, reported benefiting from training in coping strategies along with other carers from a locally based Professor of Psychiatry. Carers are affected heavily by admissions problems as they may be left to care for people with complex and severe conditions in an acute phase of illness.¹⁴ The Commission was told that carers benefit from a clear understanding of the purpose of an acute inpatient admission. A lack of clarity about what inpatient

and community care are both for can lead to carers pushing for inpatient care as they want the patient to be in what is perceived to be the safest environment, when community alternatives might actually be more appropriate.

Many carers stressed to the Commission how important it is to be included in the assessment when the patient is being admitted to hospital – and many reported that this didn't happen, sometimes for logistical reasons but often also because they were forgotten or actively excluded from the process. However, there are risks with involving carers in some instances. Carers can be understandably susceptible to 'overprotect' the patient when the care burden is very heavy, or as the result of stigma/guilt, but this can lead to disempowerment. The Commission acknowledges the need to educate carers and support them in developing strategies to enable greater independence of the person they care for. Charities such as CAUSE provide volunteer peer support for carers and patients. The Commission believes that mental health providers should introduce Carer Support Workers who can support carers along the recovery journey and enable them to learn the pathways and strategies that are successful in supporting someone in distress.¹⁵

The Commission has been told that some mental health services refuse to engage with carers on the grounds of patient confidentiality. If a patient has not given consent for information about their treatment to be shared, then this can only take place in very specific circumstances such as in cases when not doing so would represent a risk to the public interest. However, the Commission notes that there is no rule stipulating that mental health services cannot receive and act on information that carers provide to them, and given that many early signs of deterioration will first be perceived by carers due to their proximity to the patient this information should be taken extremely seriously.^{16,17}

The Commission was told by its Service User and Carer Advisory Group that patients are sometimes discharged prematurely without adequate support in the community and without adequate consultation with carers. This was repeatedly linked to bed pressures.

Other challenges faced by carers include not being adequately involved in planning patient recovery and services not taking carer concerns about a patient's health seriously. They strongly felt that carers need more support.

Box 4.2: The Triangle of Care¹⁹

The Triangle of Care has six elements:

- 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.

The Triangle of Care

Several people mentioned to the Commission the importance of the Triangle of Care. This was created by the Carers Trust and sets out six standards that services should achieve to ensure that carers are engaged and supported at all levels of service delivery, from individual care to service planning as shown in Box 4.2. It is designed to help build a therapeutic relationship between all involved in mental health care, support recovery, sustain wellbeing and promote safety.¹⁸

Involving patients and carers in care

Although research from Northern Ireland published in 2009 raised doubts about whether the rhetoric of patient involvement has been genuine and/or adequately resourced,²⁰ the Commission saw and heard of a wide range of examples where patients are involved in service planning and delivery as well as in decision-making about their own care.

Patient and carer involvement is not just about involvement in individual care, but is also about involvement in commissioning and developing mental health services. Involvement brings greater ownership of services and fosters a better understanding of how and why services are developed, resulting in mutual benefit for all. Patients and carers bring with them their own knowledge and expertise of mental illness and of accessing mental health services and offer different perspectives and priorities for service improvement. Involving patients in mental health services may also be therapeutic, increasing confidence and self-esteem and promoting social inclusion.

In particular, the Commission has heard that Trusts need to invest further in training, development and support for patients and carers in order for them to be able to participate fully. Training and support are vital to prevent tokenism and ensure that there is proper consultation based on an equal partnership between services and patients and carers.

The Commission noted that many providers were very open to these ideas and that there is considerable experimentation with different models across the UK. It also notes that there is, as yet, little formal evaluation of the effects of these various schemes nor of how they can be managed for maximum impact. However, there are promising signs that greater engagement and giving more responsibility to patients and carers is beneficial.

The Commission saw and heard of examples where patients are involved in service planning and delivery as well as in decision-making about their own care.

Peer support and advocacy

The Commission saw a number of peer support schemes in action and heard about others in existence or being developed around the Region. Peer support workers are people with personal experiences of mental health problems who use these experiences to support others with mental health problems. Peer support may also be described as *"a system of giving and helping founded on key principles of respect, shared responsibility and mutual agreement of what is helpful"*.²¹

There is a wide range of different kinds of peer support. Peers may be paid or voluntary, trained or untrained, employed in hospitals or in the community, delivering their services one-to-one, or via telephone, online or in small group settings. They may be a formal part of the clinical team or an informal grouping sometimes run by a charity or a purely informal arrangement of mutual support between people who know each other. An example of a peer support and advocacy scheme in Belfast is provided in Box 4.3 below.

Despite the growing popularity of peer support schemes the Commission notes that there is little well-designed research on the impact of peer support and that what exists is generally inconclusive. Given that Northern Ireland is leading the way on these schemes within the UK, the Department of Health should consider how it could support further research and evaluation of its programmes.

Peer managed support houses and community services for respite, crisis care and building resilience.

The engagement of peers has been taken further in a number of instances with the creation of residential and crisis houses run by patients and former patients, including one which the Commission visited in Belfast.

Non-residential community-based services designed to build resilience prevent admission also exist. An example of such a peer managed support service – The WELL Project – is provided in Box 4.4 below.

Like other forms of peer support there has been very little research undertaken on these developments and there is little evidence about how they can be used most effectively as part of wider service delivery. Trusts should consider conducting formal evaluations of such initiatives.

Box 4.3: Peer advocacy and support in Belfast

Belfast Health and Social Care Trust (BHSCT) was the first Trust in Northern Ireland to employ a Service User Consultant, who works within the mental health management team. They have also worked with a patient-led group since 2001 when the Trust supported the group to open premises in the city centre to support patients in their journey of recovery. This group holds a unique contract with the Trust.

Part of this contract is that they monitor the mental health services within the Trust as an independent patient and peer advocacy group.

BHSCT now has contracts with six community sector organisations for the provision of a range of independent advocacy services for patients and carers within mental health. This includes independent advocates who are core members of specific mental health teams. They currently have three established Peer Support Workers embedded in Community Mental Health Teams (CMHTs) across the city and they also plan to employ a further four to five more Peer Support Workers in specialist teams and in their inpatient settings.

Advocates and members of the patient user group take part in a range of roles including:

- Attending operational management meetings.
- Budget setting and monitoring.
- Supporting patients' and carers' meetings with service managers.
- Supporting mental health governance.
- Helping with the design of the new-build facilities e.g. new inpatient service and building.
- Assisting in the operation of the:
 - Inpatient Forum
 - Change Of Mind Group along with BHSCT's community and voluntary partners
 - Team Audit and User Satisfaction, eg. Home Treatment Team (HTT) patient feedback.

Advocacy services are provided in line with the code of practice for independent advocates. This provides a clear description of what is and is not expected of an advocate in their day-to-day work with patients.

Box 4.4: The WELL Project²²

The WELL Project aims to maintain wellbeing and build the resilience of women with mental health needs through a peer led approach. It has a five year track record of providing peer-led support and activity programmes for women with longstanding, serious mental health difficulties, within Belfast.

The service provides peer-led support groups and varied programmes of activities such as arts and crafts, cookery, gardening, creative writing, and personal development workshops. The WELL Project is a peer led organisation, managed and facilitated by women who have, themselves, had mental health difficulties.

The Project facilitates the empowerment of women with mental health needs, and assists positive mental health recovery, through a holistic, empathetic approach, in a safe, inclusive, nurturing environment. All participants are encouraged to have active input in planning programmes, contribute to fundraising activities and have the opportunity to volunteer within the organisation. Throughout 2013, the organisation provided support and activity programmes to over 50 women.

The Commission recommends that:

5. Support for patients and carers.

The current programmes for engaging and supporting patients and carers should be continued with greater emphasis given to the early involvement of carers wherever possible and appropriate.

This will involve providers working with commissioners, patients and carers to evaluate current patient and carer involvement in service planning and delivery, and improve it as necessary; evaluating promising schemes such as peer support and advocacy services and peer-led services, in order to demonstrate their efficacy, identifying how they can be improved and share good practice; ensuring that patients and carers involved in service planning or delivery functions receive the training, development and support they need to do so; assessing whether current policies re the involvement of police in assessments/admission are appropriate and implementing and monitoring the Triangle of Care.

References

- ¹ National Audit of Schizophrenia (2014). *Report of the second round of the National Audit of Schizophrenia (NAS2) 2014: Report for Northern Ireland*. Available at: <http://www.rcpsych.ac.uk/pdf/NAS2%20NI%20national%20report%20FINAL.pdf> [Accessed 22 April 2016]
- ² See <http://www.imroc.org/> for more information
- ³ Guidelines and Audit Implementation Network (2013). *Regional Audit of the Experience of Users & Carers within Mental Health Services*. Belfast: GAIN. Available at: <http://www.cypsp.org/wp-content/uploads/2014/08/GAIN%20-%20Mental%20Health%20Audit%20-%20Experiences%20of%20Users%20%20Carers%20June%202013.pdf> [Accessed 14 January 2016]
- ⁴ National Audit of Schizophrenia (2014). *Report of the second round of the National Audit of Schizophrenia (NAS2) 2014: Report for Northern Ireland*. Available at: <http://www.rcpsych.ac.uk/pdf/NAS2%20NI%20national%20report%20FINAL.pdf> [Accessed 22 April 2016]
- ⁵ Ulrich, R., Zimring, C., Quan, X., Joseph, A. & Choudhary, R. (2004). *Role of the Physical Environment in the Hospital of the 21st Century*. The Centre for Health Design. Available at: www.healthdesign.org/chd/research/role-physical-environmenthospital-21st-century [Accessed 14 January 2016]
- ⁶ Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. & Faulkner, L. (2015). *Regress? React? Resolve?: An evaluation of mental health service provision in Northern Ireland*. Available at: http://pure.qub.ac.uk/portal/files/17051927/Regress_React_Resolve.pdf [Accessed 17 May 2016]
- ⁷ Action on Hearing Loss Northern Ireland (n.d). *Hearing Matters*. Available at: https://www.actiononhearingloss.org.uk/~media/Documents/Policy%20research%20and%20influencing/Research/Hearing_Matters_2015/HearingMatters_NISupplement.ashx [Accessed 24 May 2016]
- ⁸ Regulation and Quality Improvement Authority (2014). *Audit of Treatment Plans Mental Health (Northern Ireland) Order 1986 1 November 2013 to 31 August 2014*. Available at: http://www.rqia.org.uk/cms_resources/Treatment%20Plan%20Audit_Nov1314.pdf [Accessed 31 May 2016]
- ⁹ National Audit of Schizophrenia (2014). *Report of the second round of the National Audit of Schizophrenia (NAS2) 2014: Report for Northern Ireland*. Available at: <http://www.rcpsych.ac.uk/pdf/NAS2%20NI%20national%20report%20FINAL.pdf> [Accessed 22 April 2016].
- ¹⁰ Davidson, G. & Campbell, J. (2010). An audit of assessment and reporting by Approved Social Workers (ASWs). *British Journal of Social Work*, 40(5), pp1609-1627
- ¹¹ Guidelines and Audit Implementation Network (2016). *Regional Audit of Assessments for Admission under the Mental Health (Northern Ireland) Order 1986*. Available at: http://www.rcpsych.ac.uk/pdf/Regional_audit_of_assessments_under_MHO_.pdf [Accessed 06.06.16]
- ¹² Quote taken from the Law Centre NI response to the Commission's Call for Evidence, April 2015)
- ¹³ National Audit of Schizophrenia (2014). *Report of the second round of the National Audit of Schizophrenia (NAS2) 2014: Report for Northern Ireland*. Available at: <http://www.rcpsych.ac.uk/pdf/NAS2%20NI%20national%20report%20FINAL.pdf> [Accessed 22 April 2016].
- ¹⁴ Royal College of Psychiatrists (2014). Annual Conference of the RCPsych Service User and Carer Fora 14 December 2014, held at the Royal College of Psychiatrists, London
- ¹⁵ Machin, K., & Repper, J. (2013). *Recovery: a carer's perspective*. London: Centre for Mental Health and Mental Health Network, NHS Confederation. Available at: http://www.nhsconfed.org/~media/Confederation/Files/public%20access/ImROC_briefing_Carers_ImROC.pdf [Accessed 21 January 2016]
- ¹⁶ Rethink Mental Illness. *Confidentiality and information sharing for carers, friends and relatives*. Available at: www.rethink.org/resources/c [Accessed 22 January 2016].
- ¹⁷ General Medical Council (2009). *Confidentiality: guidance for doctors*, para 66. Available at: www.gmcuk.org/static/documents/content/Confidentiality_0910.pdf [Accessed 22 January 2016]
- ¹⁸ Carers Trust (2013). *The Triangle of Care. Carers Included: A Guide to Best Practice in Mental Health Care in England*. Available at: <https://professionals.carers.org/sites/default/files/media/the-triangle-of-care-carers-included-final-6748.pdf> [Accessed 21 January 2016]
- ¹⁹ Carers Trust (2013). *The Triangle of Care. Carers Included: A Guide to Best Practice in Mental Health Care in England*. Available at: <https://professionals.carers.org/sites/default/files/media/the-triangle-of-care-carers-included-final-6748.pdf> [Accessed 21 January 2016]
- ²⁰ Heenan, D. (2009). *Mental Health Policy in Northern Ireland: The Nature and of Extent of User Involvement Social Policy and Society*, Vol 8(4), pp. 451-462
- ²¹ Mead, S. (2003). *Defining peer support*. Available at: www.intentionalpeersupport.org/wp-content/uploads/2014/02/Defining-Peer-Support.pdf [Accessed 29 January 2016]
- ²² See <http://www.communityni.org/organisation/well-project#V1VkQfkrLcs> for more information

05

Supporting the system: funding, staffing and information

Summary

This chapter briefly reviews three of the elements that need to be in place for the mental health system to function effectively – adequate funding and staffing and good information systems.

It shows that funding for mental health is proportionately lower than elsewhere in the UK despite the higher levels of need.

It argues that some of the funding needed for additional community and specialist services as well as for supported housing could come from Invest to Save schemes but that additional resource is needed. It also argues that commissioning needs to be improved.

The chapter goes on to describe the pressures on staff and the need for training and development as well as the need for better information systems. Its recommendations cover investment in new services, commissioning and data collection.

Funding

Mental health in Northern Ireland appears to have been funded less well than elsewhere in the UK over a number of years both in terms of its share of the overall health budget and on a per capita basis. Comparisons are difficult to make because of some differences in accounting practices and collection systems, however, a number of studies over the years as described below have reached the same conclusion.

This relative underfunding is despite Northern Ireland having the highest prevalence of mental illness in the UK.¹ DHSSPS reviews of health and social care have found the level of mental illness to be 20-25% higher in Northern Ireland than England or Scotland.^{2,3} The suicide rate in the general population is currently the highest in the United Kingdom.⁴

In 2006/7, mental health received 9.3% of the overall health budget in Northern Ireland compared to 11.1% in Scotland and 11.8% in England.⁵ A 2004 study estimated that in 2002/3 per capita expenditure on mental health was 15.6% lower in Northern Ireland than in England.⁶ A subsequent 2010 McKinsey report suggested that once allowance was made for the higher levels of need, Northern Ireland spends less than half of England's per capita spend on supporting people with mental health problems and Learning Disability,⁷ and research conducted in 2011 found that actual spending per capita on mental health services in Northern Ireland is 10-30% lower than in England, despite requiring nearly 44% higher per capita funding.⁸

Non-inflation adjusted figures for the overall mental health 'Programme of Care' budget in Northern Ireland for the period 2004/5 – 2012/13 are presented below in Table 5.1. These figures do not include funding for old age psychiatry, which is accounted for separately.^{9,10}

In the 2011-15 Budget, the Northern Ireland Executive stated its continuing commitment to the implementation of the Bamford Review on mental health, in particular improving early intervention, further developing community services, further reducing long-stay hospital populations, improving prison mental health services and expanding provision for children and young people. However, the second Bamford Action Plan, 2012-15, acknowledged that funding will continue to be a significant challenge in the period to 2015. In stark contrast with the anticipated

Table 5.1: Non-inflation adjusted figures for the overall mental health 'Programme of Care' budget

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

budget at the outset of the 2009-11 Action Plan, the only additional funding to the Health and Social Care sector earmarked for mental health services over the 2011-15 budget period was £2.8m.¹¹

As noted in Chapter One, the Commission was repeatedly told that mental healthcare budgets were sometimes used to cover shortfalls in physical healthcare budgets.

Mental health funding has also fared badly both in terms of actual (as opposed to budgeted spending) and in comparison to other health specialties. As the 2015 Queen's University Belfast report *Regress? React? Resolve?* showed, between 2008 and 2014 actual spend on mental health services by Trusts was around 25% less than previously proposed. This compares extremely badly with other areas of healthcare; although funding for primary care for example increased by 136.2%, mental health services have experienced real-terms year on year decreases in funding over the same period since 2009.¹²

Analysis of Trust financial returns between 2009/10-2013/14 shows that the mental health Programme of Care was the only area of healthcare which saw a fall in its share of the health budget over the period. This information is presented in Table 5.2.

Looking forward, the 2015 *Regress? React? Resolve?* report also cautioned that *"Mental health commissioners unanimously agreed that the most serious limitation and greatest challenge facing mental health services stemmed from the impact of continuing financial restraint... Indeed, not only were commissioners worried about securing the continuing financial investment necessary to deliver the Bamford Vision, but several also expressed serious concern about the danger of existing provision being cut-back."*¹⁴

Table 5.2: Change in mental health expenditure by five HSC Trusts for different programmes of care (based on Trust financial returns, 2009/10-2013/14)¹³

	Cash terms	Real terms		Real terms	
Expenditure £m	2009/10	2009/10	2013/14	Variance	%
POC1: Acute Services	1,289	1,399	1,437	38	3%
POC2: Maternity and Child Health	145	157	157	0	0%
POC3: Family and Childcare	188	204	213	8	4%
POC4: Elderly Care	708	768	782	14	2%
POC5: Mental Health	225	245	234	-11	-4%
POC6: Learning Disability	228	248	267	19	8%
POC7: Physical and Sensory Disability	101	109	111	2	2%
POC8: Health Promotion and Disease Prevention	47	51	56	5	10%
POC9: Primary Health and Adult Community	125	136	208	72	53%
Total expenditure by programme	3,058	3,317	3,464	147	4%

Extra-Contractual Referrals

Millions of pounds are spent every year transferring acutely unwell patients abroad for care. These transfers – known as Extra Contractual Referrals (ECRs) – occur when the Health and Social Care Board approves a consultant's request to transfer a patient to another part of the UK for assessment or treatment, which the consultant considers necessary but is not available through facilities in the Region. Exceptionally, patients may also be transferred to a provider outside the UK where it is clinically justified.

Table 5.3 below provides summary information on the number of ECRs within the non-acute programmes of care which includes mental health. It shows that the numbers of new ECRs approved in any given year (Column 1) are low. However, these cases can be for periods of care which span a number of financial years and in some cases can be open-ended. Column 2 shows the number of on-going cases receiving funding support in each year.

The Commission understands that non-acute ECRs attract a much higher cost per patient in contrast to acute referrals and it notes that concerns about the costs of ECRs relating to Eating Disorders have resulted in a feasibility study focusing on whether an inpatient service should be established.¹⁵ The Region-wide service capacity assessment and improvement review recommended in Chapter Two should establish the extent to which both community and inpatient specialist services are required, and the Commission hopes that this will both reduce the costs incurred by ECRs and also improve clinical outcomes and patient and carer experience.

Table 5.3: Number of non-acute ECRS (including mental health)

Year	Total number of ECRs approved in year	Total number of ECRs with mental health supported	Cost of ECRs with mental health presenting issue (£m)
FY2012-13	21	52	7.2
FY2013-14	23	62	7.1
FY2014-15	32	68	7.5
FY2015-16	28	64	8
Total	104	246	29.8

Comparative spending figures between different hospital sites

The Commission experienced difficulties acquiring detailed spending figures. Some insights can however be drawn from the limited available information. Data are available from the DHSSPS on the costs of acute inpatient care (excluding old age psychiatry) in different hospitals.¹⁶ These figures are presented in Table 5.4 below.

Table 5.4: Costs of acute inpatient care (excluding old age psychiatry) in different hospitals

Mental health inpatient services: cost per patient week	Causeway	Bluestone Unit	Downshire	Gransha	Holywell	Knockbracken Healthcare Park	Mater	Tyrone & Fermanagh	Ulster
	£	£	£	£	£	£	£	£	£
Acute care	2,272	1,928	2,856	2,309	2,395	2,336	2,203	2,377	2,281

Costs per inpatient week range from £1928 to £2856, with an average figure of £2,329. The variation in cost, where the highest figure is nearly one and a half times the lowest figure, seems extreme in the Commission's view. Moving towards a single mental health service for Northern Ireland (as recommended in Chapter One) will provide an opportunity to reduce variation through the provision of consistent high-quality care.

Investing to save

There is in many instances a strong economic case for investment. As described in Box 5.1, many mental health services operate on either a cost-neutral or cost-saving basis.

Box 5.1: Examples of cost-saving mental health services

- Early intervention for psychosis leads to total returns of £17.97 for every £1 invested, with net savings starting by year one.
- A liaison psychiatry service can save up to £5 million in a typical hospital every year. The net benefits of pre-school educational programmes for 3- and 4-year-olds with low IQ and low income are the equivalent of £17 for each £1 invested.
- Prevention of conduct disorder through school-based social and emotional learning programmes results in total returns of £83.73 for every £1 invested. Cost savings over 2 years are more than twice the initial investment, with cumulative gross savings per child of £6369 after 5 years and £10032 after ten years.
- Early diagnosis and treatment of depression at work results in total returns of £5.03 for every £1 invested, with net savings starting by year one.
- Suicide prevention through GP training results in net savings of £44 for every £1 invested.

Investing to save

There is in many instances a strong economic case for investment. As described in Box 5.1, many mental health services operate on either a cost-neutral or cost-saving basis.

In addition to these services it is clear from the discussion in Chapter Two and elsewhere that the current functioning of the whole system is both ineffective and inefficient. Patients delayed in hospital or treated in the wrong location not only experience poor quality of service but represent a considerable wasted cost within the system. The Commission has not attempted to quantify this but would argue that improving the functioning of the service – often through investment in different services – will have direct cost benefits in the longer run and provide more appropriate treatment for patients.

Invest to Save

Northern Ireland has previously used an Invest to Save approach to drive improvement. Although this initial tranche of spending experienced mixed success, the Commission notes that lessons have been learnt from the experience¹⁷ and would encourage the introduction of a subsequent programme with funding available to deliver

Box 5.2: The 2010-2015 Invest to Save programme¹⁸

In December 2009, as part of its 2010-11 Review of Spending Plans, the Executive agreed that an Invest to Save fund should be established in Northern Ireland. Between 2010 and 2015 £311 million was spent on projects. Of this, £254 million was spent by Government departments on 31 Invest to Save projects.

Broad criteria for the candidate proposals were that they would reflect:

- Savings;
- Impact on Programme for Government;
- Deliverability of savings;

Although the available funding was in respect of current expenditure, there was scope for departments to put forward proposals involving capital investment.

The DHSSPS received a significant amount of Invest to Change funding, and allocated some of this funding to service change projects. £4.6 million was allocated (and £3.7 million spent) in support of a number of key projects including strengthened Percutaneous Coronary Intervention services, support for Stroke service change, and work to build up a Reablement approach to community care. An estimated £7.4 million of annual savings have been identified.

the 2016-2021 Programme for Government's putative objective of improving mental health. More information about the 2010-2015 scheme is provided in Box 5.2.

Commissioning and payment systems

The commissioning arrangements were described in Chapter One together with the critique of them both by the last Health Minister and the Donaldson Report. This Commission entirely supports the need for change and would argue that a new approach is needed – more modelled on the Scottish practice than the English – that is robust enough to lead the changes needed in the whole system.

There are also problems with the mechanisms used for funding providers. As the 2014 Donaldson Report pointed out, Northern Ireland utilises a payment system based on unsophisticated 'block' contracts. It noted with concern that with respect to physical (not mental) healthcare

*"this approach was abolished years ago in England because it was considered old-fashioned, crude and not conducive to achieving value for money. Fully developed tariff systems reimburse providers on a case-by-case basis, with the amount paid dependent on the diagnosis or the procedure undertaken, the complexity of the patient and, in some cases, measures of the quality of care. In Northern Ireland, the funding system is far more basic."*¹⁹

The Commission believes that moving to an alternative system to incentivise providers to deliver and develop effective services throughout evidence based pathways (and not to concentrate purely on activity levels undertaken by individual providers) should be a priority.²⁰

Any payment system for mental health should be based on diagnosis and allow for complexity. It needs to be informed by accurate information on the services provided, and the costs and quality of what is being commissioned. Transparency of the evidence base, the description of what a service provides, the cost of this provision and its quality are key areas for allowing a payment system to operate fairly and to encourage improvement.²¹

Staffing

The description of services in earlier chapters shows how much pressure there is on staff throughout the system. There are some staff shortages particularly in psychology and nursing – where numbers of mental health nurses appear to be stable over recent years. Generally speaking, vacancy rates for consultant psychiatrists are low.

A 2015 Royal College of Nursing report showed that the number of mental health nurses decreased by 1% between 2010–2013, whilst the numbers of nurses overall has increased by 1%. Numbers were fairly stable going into 2014 with a total of 1636 mental health nurses recorded – an increase from 1617 in 2013).²²

Vacancy rates for mental health nurses have been gradually rising since 2009 from 0.5% of the WTE workforce in March 2009 to 3.6% in the March 2015 figures.²³ Three month vacancy rates are also rising, reaching 2.1% in March 2015. However, vacancies in mental health nursing were lower than for acute nursing (3.6% WTE vs. 4.6% WTE). Long term vacancies were also low at 0.7%.²⁴

Data on the use of agency staff is not officially published, but a recent Northern Ireland Executive evidence submission to the 2016 National Health Service Pay Review revealed that agency spending across the Health and Social Care Trusts had risen from £44 million in 2010/11 to £77 million in 2014/15, with increases in spending expected to continue into 2015/16.²⁵

Leadership and culture

Almost everyone who spoke to the Commission stressed the importance of leadership and culture and the vital role that staff attitudes and behaviour play in caring for people.

The Commission does not advocate any particular model of leadership and leadership development – other than noting the importance of open inclusive leadership of the sort displayed in many of the examples of good practice given in this report; however, it does consider that this needs to be high on the agenda of every Board – not just the executives – because leadership style influences activity through an organisation and shapes its culture. Leadership development needs to extend to every part of an organisation – wards, community teams, support services and management – wherever people take responsibility for ensuring that services are delivered and things get done.

The Commission believes that it is important that each Trust has their own scheme which is led from Board level and incorporates not only the values of the Trust but also gives leaders throughout the organisation shared models and language for focusing on quality, communication, bringing about change and getting the most from their staff.

Whilst these programmes must relate to other programmes run Regionally or locally, it is essential that these programmes are locally based and assist with the development of the whole organisation as well as the individual.

These leadership development schemes should be available to everyone in a leadership role within the organisation but Trusts should consider giving a measure of priority to ward managers and their equivalents as team leaders of the various community based teams.

Leadership is important for many reasons from setting direction to ensuring organisational sustainability and performance. It is absolutely essential for developing motivated and high performing staff. Moreover, there is now a well-established relationship between how staff feel about their work and how they are managed on the one hand and how well they look after patients on the other.²⁶

Development and training

The changes envisaged by current strategies for mental health with their shift towards community based provision, the need for greater knowledge of quality improvement, and the necessary improvements in cross-boundary working mean that there is very large training and development agenda for staff within the whole system.

The Commission notes that great efforts are being made to facilitate this but that this needs to remain a priority for the future.

Data and outcomes

The Commission has received a clear message from the people to whom it has spoken that better data are required to inform day to day management of services and commissioning as well as to help drive improvement. This is supported by the 2014 King's Fund report into Northern Ireland's integrated commissioning of health and social care. The report concluded that *"the integrated health and social care system has not realised its full potential and the opportunities provided by the structural organisation have not been fully exploited. A key issue in Northern Ireland is the lack of robust evidence to assess and evaluate the outcomes of this unique system. The effectiveness or otherwise of the integrated system is difficult to assess owing to the weakness of the existing data, which is particularly limited in terms of evidence of improved patient outcomes."*²⁷

The 2014 Donaldson Report also drew attention to the latency and poor coverage of current data collection, and called for targeted investment in this area. Box 5.3 contains an extract from the report.

The Commission heard that the five different Trusts all have different information systems, which do not necessarily 'talk' to each other. It was told that a Regional minimum dataset is being developed to address this, which is promising. The Commission suggests that the constituent data be securely uploaded by each Trust to a Regional database, which can both serve as a translator for moving information between Trusts if patients move, and also facilitate Regional level data analysis.

It is imperative to address the three issues of local operational data, Regional collection and the development of the minimum dataset as a prelude to dealing with other developments in information use. However, there are two other developments which will also need attention in the near future. These are:

Box 5.3: Extract from the Donaldson Report about data collection

"The Northern Ireland Health and Social Care system has no consistent method for the regular assessment of its performance on quality and safety at regional-level, Trust-level, clinical service-level, and individual doctor level. This is in contrast to the best systems in the world.

Too often, data show where the system was over the last three months, or what performance has been across large units. They need instead to show the situation in real-time, or as near to it as possible. And they need to show performance at the very local level. As with culture and leadership, data capability is an area that the best care systems in the world have invested in heavily. They have online dashboards that enable all aspects of the system to be measured, understood, and therefore managed. In comparison, Northern Ireland (and many other places) has a care system that is being managed as if through a blindfold. Investment in information technology is crucial and, if done intelligently, will pay dividends".

- Making evidence and decision support available to clinicians.
- The use of information systems in the management of individual patients.

Clinical information systems can be developed to both present recommended interventions via a structured decision-making tool and collect information on the interventions offered to and received by each patient. The presentation of clinical decision-making information will prompt behaviour change to reduce unwarranted variation in the provision of NICE-guideline concordant care, and the evaluation of what interventions are actually received will provide data to measure this.

Information systems which collect and present individual patient data will allow the much closer monitoring of care and help improve patient management. Some of these are already being developed in the UK and abroad. Mental health is to some extent behind physical health in the use of measurement and informatics but in the next few years we should anticipate that it will be normal for:

Box 5.4: The use of Smart Boards

Smart Boards are in operation in each Trust in Northern Ireland, replacing an outdated patient management system that had been in operation since the 1980s. Information is securely available to community and inpatient teams as well as to social services, enabling a patient's progress through the acute care pathway to be tracked and discharge planned further in advance so as to reduce delays. As well as facilitating bed management the Smart Boards also act as a clinical tool by allowing interventions to be scheduled and risk levels better monitored and addressed as necessary.

Once improvements have been made to the technology, Trusts will be able to see the status of beds from across the whole Region, with enhanced capability to track out-of-area placements, address the purpose of admission and record patient outcomes. A representation of one of the Smart Board screens is depicted below, illustrating in particular the 'traffic light' system which offers at-a-glance information.

Add patient

Patient Card	Admission	Care Plan	Demographics	Discharge	Mental Health Order	Mental Health Rights	Other
H&C Number	Name	Gender	None	Male	Female		
DoB	Age	Locality					
Cons	Named Nurse						
Adm Hosp Date	Adm Hosp Time	D of Dis					
Spec Obs	Spec Obs Rv Date						
MHO	No Requirement	Detained	Voluntary				
Pre-Dis IV Carers	No Requirement	Required	In Progress	Complete			
Assess	Not Assessed	No Requirement	Required	In Progress	Complete		
CRR	Not Assessed	No Requirement	Required	In Progress	Complete		
MD Care Plan	Not Assessed	No Requirement	Required	In Progress	Complete		
DIS Plan	Not Assessed	No Requirement	Required	In Progress	Complete		
7 Day Follow-up	Not Assessed	No Requirement	Required	In Progress	Complete		
Ref Agent	Not Assessed						
RtoA - Social Worker	Not Assessed	Not Received	Required	In Progress	Complete		
RtoA - ATU	Not Assessed	Not Received	Required	In Progress	Complete		
RtoA - APTS	Not Assessed	Not Received	Required	In Progress	Complete		
RtoA - Forensic Service	Not Assessed	Not Received	Required	In Progress	Complete		
RtoA - Psycho-Sexual Service	Not Assessed	Not Received	Required	In Progress	Complete		
Infec	Please select ...						
MHO Form Number	Next Form Due	Allergies	No	Yes			
Diabetic	No	Yes					
Epilepsy	No	Yes					
Zoning	High	Medium	Low	No Zoning			
Leave Type	Due Back	Leave	Leave Frequency				
Leave Start Date	Leave Start Time						
Date of Transfer							

Save Don't Save

- Providers to be able to access in real time data about individual inpatients that records diagnosis, anticipated date of discharge, past and planned interventions, physical records and much more – which will enable better review and management of patient care.
- Providers and commissioners together being able to access such data in a suitably aggregated and anonymised form so as to manage the system, the quality of its outcomes and expenditure as a whole – thereby helping drive improvement.
- Patients having access to all data and information about themselves together with explanations of technical issues and management plans – thereby enabling them to be co-producers of their health with their professional, formal and informal carers.

The Commission is pleased to note that progress is being made in some areas. Box 5.4 describes the ‘Smart Board’ bed management system being used in each Trust.

Outcome measures

The Commission was told that better outcome measures would be welcome. Alongside robust clinical outcomes measures, it is vital to measure what is actually meaningful for patients. As noted in Chapter Four, there is variation between different measures of patient experience. Introducing a Region-wide ‘Friends and Family Test’ which captures both patient and carer experience would be one mechanism for doing this.

The Commission recommends that:

6. Investment for better value and improved quality. There needs to be further investment in community services and new investment in specialist services and supported housing. Some of this can be achieved through an Invest to Save Programme which could be designed to reduce waste in the system and improve the efficiency of the whole service.

7. Commissioning. The current system of commissioning services needs to be replaced by a simpler and more rigorous evidence-based approach and better financial mechanisms.

8. Improved data. The collection, quality and use of clinical, financial, patient and carer experience and organisational data needs to be radically improved – with the introduction of a minimum data set – so they can be used to improve services and efficiency, ensure evidence-based care is delivered and improve accountability.

References

- ¹ Friedli, L. and Parsonage, M. (2007). *Mental health promotion: Building an economic case*. Available at http://www.chex.org.uk/media/resources/mental_health/Mental%20Health%20Promotion%20-%20Building%20an%20Economic%20Case.pdf [Accessed 16 May 2016]
- ² Department of Health, Social Services and Public Safety (2002). *Effectiveness Evaluation: Health and Social Care*. Belfast: DHSSPSNI
- ³ Department of Health, Social Services, and Public Safety (2011). *Transforming Your Care: A Review of Health and Social Care in Northern Ireland*. Belfast: DHSSPSNI. Available at: <http://www.transformingyourcare.hscni.net/wpcontent/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf> [Accessed 31 May 2016]
- ⁴ The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2015). *Annual Report: England, Northern Ireland, Scotland and Wales*, p.11. Available at: <http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked.pdf> [Accessed 31 May 2016]
- ⁵ Friedli, L. and Parsonage, M. (2007). *Mental health promotion: Building an economic case*. Available at http://www.chex.org.uk/media/resources/mental_health/Mental%20Health%20Promotion%20-%20Building%20an%20Economic%20Case.pdf [Accessed 16 May 2016]
- ⁶ The Northern Ireland Association for Mental Health (2014). *Counting the Cost: The Economic and Social Costs of Mental Illness in Northern Ireland*. Available at http://www.niamhwellbeing.org/SiteDocuments/niamh_counting_cost.pdf [Accessed 16 May 2016]
- ⁷ McKinsey (2010). *Reshaping the system: implications for Northern Ireland's health and social care services of the 2010 spending review*. Belfast: DHSSPSNI
- ⁸ Appleby, J. (2011). *Rapid review of Northern Ireland health and social care funding needs and the productivity challenge: 2011/12-2014/15*. Belfast: DHSSPSNI
- ⁹ Northern Ireland Assembly (2011). *Research and Information Service Briefing Note: The DHSSPS budget – where does the money go?* Belfast: Northern Ireland Assembly
- ¹⁰ Department of Health, Social Services and Public Safety (2013). *Health and Social Care Expenditure Plans for Northern Ireland: 2012/13 Supplementary analysis to the HSCB/PHA Commissioning Plan 2012/13, Chapter 2 – Ensuring Financial Stability and Effective Use of Resources*. Belfast: DHSSPSNI
- ¹¹ Northern Ireland Assembly (2012). *Delivering the Bamford Vision The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan 2012-2015*. Belfast: DHSSPSNI
- ¹² Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. & Faulkner, L. (2015). *Regress? React? Resolve?: An evaluation of mental health service provision in Northern Ireland*. Available at: http://pure.qub.ac.uk/portal/files/17051927/Regress_React_Resolve.pdf [Accessed 17 May 2016]

- ¹³ Health and Social Care Board (2015). *NI HSC Financial Overview Expenditure Review 2009/10-2013/14 & Planning to 2015/16*. Available at: <http://www.hscboard.hscni.net/board/meetings/January%202016/Item%2012%20-%2002%20-%2005%20Year%20Review%20Report.pdf> [Accessed 26 May 2016]
- ¹⁴ Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. & Faulkner, L. (2015). *Regress? React? Resolve?: An evaluation of mental health service provision in Northern Ireland*, p74. Available at: http://pure.qub.ac.uk/portal/files/17051927/Regress_React_Resolve.pdf [Accessed 17 May 2016]
- ¹⁵ Belfast Telegraph (2015). *Ill Emma's family hail news Northern Ireland may get own eating disorders clinic*, 08 October 2015. Available at <http://www.belfasttelegraph.co.uk/news/health/ill-emmas-family-hail-news-northern-ireland-may-get-own-eating-disorders-clinic-31591823.html> [Accessed 23 May 2016]
- ¹⁶ Department of Health, Social Services and Public Safety (2016). *Community Service Indicators Trust Activity 2013-14*. Available at: <https://www.dhsspsni.gov.uk/publications/community-services-indicators> [Accessed 06 May 2016]
- ¹⁷ Northern Ireland Assembly (2016). *Public Accounts Committee Report on Invest to Save funding in Northern Ireland*. Belfast: NI Assembly. Available at: <http://www.niassembly.gov.uk/globalassets/documents/pac-2011-2016/inquiries/invest-to-save/web-version---report-on-invest-to-save-funding-in-northern-ireland.pdf> [Accessed 25 May 2016]
- ¹⁸ Northern Ireland Assembly (2016). *Public Accounts Committee Report on Invest to Save funding in Northern Ireland*. Belfast: NI Assembly. Available at: <http://www.niassembly.gov.uk/globalassets/documents/pac-2011-2016/inquiries/invest-to-save/web-version---report-on-invest-to-save-funding-in-northern-ireland.pdf> [Accessed 25 May 2016]
- ¹⁹ Donaldson, L., Rutter, P. & Henderson, M. (2014). *The Right Time, The Right Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland*. Available at: https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf [Accessed 25 May 2016].
- ²⁰ World Health Organization (2010). *Health Systems Financing. The path to universal coverage*. Available at: <http://www.who.int/whr/2010/overview.pdf> [Accessed 12 September 2015]
- ²¹ Royal College of Psychiatrists (2014). *Statement on Mental Health Payment Systems (formerly Payment by Results) Position Statement PS01/2014*. Available at: http://www.rcpsych.ac.uk/pdf/PS01_2014x.pdf [Accessed 23 May 2016]
- ²² Royal College of Nursing (2015). *Frontline First: The fragile frontline*. Available at: http://royalnursing.3cdn.net/9808b89b8bfd137533_krm6b9wz7.pdf [Accessed 31 May 2016].
- ²³ Department of Health, Social Services and Public Safety (2009). *Northern Ireland Health and Social Care Workforce Vacancies as at 31 March 2009*. Belfast: Department of Health, Social Services and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hsc-vacancies-march-2009.pdf> [Accessed 26 April 2016]
- ²⁴ Department of Health, Social Services and Public Safety (2015). *Northern Ireland Health and Social Care Workforce Vacancies as at 31 March 2015*. Belfast: Department of Health, Social Services and Public Safety. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hsc-vacancies-march-2015.pdf> [Accessed 26 April 2016]
- ²⁵ NHS Pay Review Body (2016). *Twenty-Ninth Report 2016*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/506030/54488_Cm_9210_NHS_PRB_2016_Web_Accessible_NEW.PDF [Accessed 3 June 2016]
- ²⁶ Dawson, J. (2009). *Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys*. Birmingham: Aston Business School. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/215457/dh_129662.pdf [Accessed 2 November 2015]
- ²⁷ The King's Fund (2013). *Integrated care in Northern Ireland, Scotland and Wales: Lessons for England*. London: The King's Fund

06

Conclusions and recommendations

Summary

This chapter brings together the findings from earlier chapters and looks towards the future. It lists all the Commission's recommendations in the final section.

Findings

The Commission found that there have been big improvements over recent years and that there are some very good services in Northern Ireland. It also noted that a great deal of effort has been put into the review and the development of policy.

There is a clear direction of travel. However, the Commission noted that the good work on policy was not yet always reflected in what happened on the ground. There was in some places a disconnection between policy and action. Implementation needs to be accelerated.

Underpinning this is the need to give mental health parity of esteem with physical health in all its aspects from funding to speed of access to care and quality of outcomes. At the same time there are structural issues about commissioning and organisation which need to be addressed.

It is particularly important that these issues are dealt with because of the large numbers of people with mental health problems and the high levels of suicide. Moreover, Northern Ireland spends proportionately less than other parts of the UK on mental health – and severely mentally ill patients cannot be certain that they will receive the same rapid access to good quality care and treatment as they would experience if they were severely physically ill.

The political background

Improvement will require political will and the understanding that good mental health is not a side issue but central to improving physical health and the social and economic well-being of the Region.

The Commission has observed that mental health is being mentioned by more and more leaders outside the health and care system and that the work by the expert panel on developing a new model for health and care clearly recognises its central importance. These are positive developments which need to be built on. The newly formed Assembly has the opportunity to provide the leadership that is needed to secure parity of esteem, reduce stigma and bring mental health into wider cross-government policy making.

Future possibilities

Mental health is a fast moving field which is attracting new prominence and priority globally as well as nationally. It is clear from listening to many of the people who contributed to this report that significant changes are underway in Northern Ireland in service models, patient

engagement, staff roles and the types of facilities needed for good mental health services. Looking ahead we can identify some possible trends which can usefully be borne in mind by people leading the implementation of the improvements envisaged by this report.

There have been significant policy developments globally in the last three years. A new Comprehensive Mental Health Action Plan was agreed by the World Health Assembly in 2013.¹ Mental health was included in the Sustainable Development Goals (SDGs) which make up the world's development agenda for 2016-2030 – having not been included in their predecessor Millennium Development Goals which ran from 2015-2030. The SDGs were agreed at the UN General Assembly meeting in September 2015.²

The SDG Declaration made clear the connections between all the Goals whether they are about economic development, the environment or social issues. It placed health firmly within these wider determinants: in effect recognising the full biopsychosocial-environmental nature of health and wellbeing. This has the effect of bringing mental health closer to other aspects of health. We could therefore expect to see more health workers who have been trained in physical health becoming much more familiar with and active in mental health. We should also see mental health workers more engaged in physical health. The current arrangements in Northern Ireland where mental and physical health are linked within Trusts should enable this to happen more easily.

Mental illnesses are now recognised globally as non-communicable diseases and many middle income countries are planning to develop their services as part of integrated chronic disease models. This brings with it the development of more preventative approaches – and the building of societies which support or create health³ – and also helps reduce the separation between the physical, social, psychological and environmental aspects of health.

The other major changes evident globally are in the training and roles of health workers and the use of technology. There is increasing use of lay and community health workers globally – supported by professionals and technology – and a re-orientation of professional training to produce professionals who are team leaders and “agents of change”.⁴ At the same time informatics and the use of data will transform decision-making and the design and delivery of services in the future.

All these trends will have their impact in Northern Ireland over the next decade and beyond.

The Commission's recommendations

The Commission's recommendations build on the current strategy and are designed to help people engaged in the sector realise their aims and ambitions

1. Parity of esteem

Mental health needs to be explicitly given equal priority with physical health by both the Department of Health and the Assembly. This would mean that mental health patients have the same levels of access and standards as for physical health, a four hour maximum wait target between the decision to treat and admission or acceptance by a CRHT should be introduced alongside a 24hr Home Treatment Team availability standard, data on performance should be published, funding must be protected, and there needs to be clear unified leadership across the whole service.

2. A single mental health service for Northern Ireland

The Department of Health, the Public Health Agency and the five Health and Social Care Trusts need to find ways to create a single service across Northern Ireland with less fragmentation of services, the adoption of common systems and standards and the development of a managed care network so as to enable more effective cross-boundary working and improve quality and efficiency.

3. Improved functioning of the whole system

Planners and providers need to work together across the Region to undertake a service capacity assessment and improvement review to ensure there are effective systems and sufficient capacity in different types of services (potentially including new specialist services) to enable patients to be cared for in the most appropriate setting.

4. Quality improvement and standards for acute adult wards

The current work to develop the capacity and capability for quality improvement throughout the whole system needs to be strengthened – to ensure everyone is working with a common approach and methodology – and linked with the development of a single set of easy to understand and measurable quality standards for acute adult psychiatric wards.

5. Support for patients and carers

The current programmes for engaging and supporting patients and carers should be continued with greater emphasis given to the early involvement of carers wherever possible and appropriate.

This will involve providers working with commissioners, patients and carers to evaluate current patient and carer involvement in service planning and delivery, and improve it as necessary; evaluating promising schemes such as peer support and advocacy services and peer-led services, in order to demonstrate their efficacy, identifying how they can be improved and share good practice; ensuring that patients and carers involved in service planning or delivery functions receive the training, development and support they need to do so; assessing whether current policies re the involvement of police in assessments/admission are appropriate and implementing and monitoring the Triangle of Care

6. Investment for better value and improved quality

There needs to be further investment in community services and new investment in specialist services and supported housing. Some of this can be achieved through an Invest to Save Programme which could be designed to reduce waste in the system and improve the efficiency of the whole service.

7. Commissioning

The current system of commissioning services needs to be replaced by a simpler and more rigorous evidence-based approach and better financial mechanisms.

8. Improved data

The collection, quality and use of clinical, financial, patient and carer experience and organisational data needs to be radically improved – with the introduction of a minimum data set – so they can be used to improve services and efficiency, ensure evidence-based care is delivered and improve accountability.

References

- ¹ World Health Organisation (2013). *Comprehensive Mental Health Action Plan 2013-2020*; WHO, Geneva, 2013, Agreed by World Health Assembly, Resolution 66/8 27 May 2013. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf?ua=1 [Accessed 10 January 2016]
- ² United Nations (2015). *General Assembly Resolution 70/1: Transforming our World: the 2030 Agenda for Sustainable Development*; 21 Oct 2015. Available at: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E [Accessed 9 January 2016]
- ³ Crisp, N. (2015). Everyone has a role in building a health creating society. *British Medical Journal*, 351:h6654
- ⁴ Frenk, J., Chen, L., Bhutta, Z.A. et al (2010). Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *The Lancet*, 376 pp1923-58

Appendices

Appendix 1:

The Commission's Terms of Reference

Purpose

The Royal College of Psychiatrists (RCPsych) has set up this Commission in response to widespread concern about whether there are sufficient acute inpatient psychiatric beds and alternatives to admission available for patients.

There is evidence - some quantified, some anecdotal – of difficulties in admissions, variable services for patients in the community, long distance transfers of patients, high occupancy rates and high stress levels amongst patients, their families, carers and staff.

The Commission is independent of RCPsych and has been asked to review the situation, examine the causes of these pressures and make recommendations for improvement. The Commission's remit covers England and Northern Ireland and 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. Although Wales was initially covered by the Commission's remit, a decision was taken in May 2015 that Welsh organisations would no longer participate.

Terms of Reference

The Commission will provide a report to RCPsych by early 2016 which will:

- 1 Identify and describe the particular purpose and value of acute inpatient psychiatric care as an integral part of the provision of services for adults needing mental health care and support
- 2 Describe the decision making processes and criteria that can most effectively be used to determine the size and scope of the inpatient service and the number of beds required to deliver safe and therapeutic care in a given area
- 3 Review the relationships between inpatient services and other aspects of the health and social care system

In doing so it will:

- Make recommendations on quality measurement and standards, planning and commissioning, the organisation and management of inpatient services, and the resources required in order to deliver safe and high quality inpatient services for patients
- Identify examples of best practice in service design and delivery and recommend methods for their spread and continuing quality improvement
- Propose an implementation plan to secure the recommendations and improvements

Exclusion criteria

The Commission will NOT examine or describe the provision of the following services, except in their relationship to acute adult services:

- services to children and adolescents and services for dementia
- specialist beds – these include, for example, mother and baby beds, forensic inpatient services, eating disorder beds, that are commissioned/provided at the national rather than local level

Composition of the Commission

The Commission consists of 15 Commissioners who will oversee the process and approve the final report and its recommendations. The Commissioners have been chosen to represent a diverse range of perspectives and experience from the various sectors involved in supporting people with mental health problems.

The Commissioners

- **Lord Nigel Crisp (Chair)** – 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
- **Anne Campbell** – Former Chair of Cambridgeshire and Peterborough NHS FT and former Vice Chair of the NHS Confederation's Mental Health Network
- **Darlington Daniel** – General Adult and Liaison Psychiatrist and Associate Medical Director for the Haverling Integrated Care Directorate at North East London NHS FT
- **Denise Porter** – Carer and Trustee of Rethink
- **Jacqui Dyer** – Mental health service user and carer and vice chair of the NHS England Mental Health Taskforce
- **John Bacon** – Chair of Barts Health NHS Trust and former chair of Sussex Partnership NHS FT
- **Laurence Mynors-Wallis** – Chair of the South West Clinical Network for Mental Health, former Medical Director of Dorset Healthcare University NHS FT and former Registrar, Royal College of Psychiatrists
- **Martin Barkley** – Chief Executive of The Mid Yorkshire Partnerships NHS Trust and Former Chief Executive of Tees, Esk and Wear Valleys NHS FT
- **Mary Riddell** – Political columnist and interviewer for *The Daily Telegraph*
- **Merran McRae** – Chief Executive of Calderdale Council
- **Michael Brown** – Mental Health Coordinator at the College of Policing
- **Paul Farmer** – Chief Executive of Mind and Chair of the NHS England Mental Health Taskforce
- **Peter Carter** – Independent management consultant and former Chief Executive of the Royal College of Nursing
- **Robert Milligan** – Independent advocate and mental health service user
- **Yvonne Coghill** – Director of Workforce Race Equality Implementation at NHS England

Advisory and supporting structure

The work of the Commission will also be supported by the Royal College of Psychiatrists via:

- Guidance from a College Lead Advisor, Dr Ranga Rao and the College Lead Advisor for Crisis Care, Dr Mary Jane Tacchi
- Occasional meetings with the College President, Division Chair in Northern Ireland and the Chair of the General Adult Psychiatry Faculty
- Support from the RCPsych Policy Unit, which will assist the Commission in gathering and analysing evidence. The unit will also provide Secretariat support and manage Commission communications and stakeholder engagement

The Commission will also consult with three advisory groups, representing a range of perspectives, insights and expertise on acute inpatient care. The Commission will engage with each group at the start of the process for guidance and comment and once again before the final conclusions and recommendations are agreed. They may also be consulted on an ad-hoc basis throughout the course of the Commission.

The groups are as follows:

- **Advisory Board** consisting of the Chief Medical Officers from each jurisdiction, (or their representatives) and other senior figures within mental health
- **Early Career Advisory Group** consisting of young professionals from psychiatry, mental health nursing, social work and clinical psychology
- **Service Users and Carers Advisory Group** consisting of representatives from third sector service user and carer groups

In addition, the Commission will seek written evidence, liaise with others working in the field, and visit services, where they will meet patients, their families and carers and staff.

Working groups

The Commission will appoint three working groups, who will each conduct further investigation into key areas of interest identified by the Commission. Each working group will be chaired by a Commissioner and will present its findings at Commission meetings.

The unique concerns and challenges facing black and ethnic minority (BME) communities engaging with mental health services will be a cross-cutting theme and taken into consideration by all the working groups.

Principles of operation

In undertaking this review the Commission will:

- Seek to understand the current situation in the context of the past – reviewing historical developments, drawing out lessons for the current situation and the future
- Take a whole systems perspective, recognising that adult inpatient care is intimately linked to community and specialist services as well as with wider health and social policy and the social environment
- Operate in an open and transparent fashion, engaging others wherever possible

Appendix 2:

Methodology and acknowledgements

Methodology

Throughout the past year, the Commission has gathered evidence from a variety of sources in order to inform the findings of this report:

1 Working Groups

The Commission established working 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
- **Patient and Carer Experience** – Yvonne Coghill, Mary Riddell, Robert Milligan, Anne Campbell and Jacqui Dyer
- **Service Models and Patient Flow** – Darlington Daniel, John Bacon, Anne Campbell, Michael Brown, Jacqui Dyer, Merran McRae, Ranga Rao
- **Staff Support, Training and Motivation** – Yvonne Coghill, Denise Porter
- **Commissioning** – Merran McRae, Ranga Rao, Anne Campbell

Where necessary, working groups were supported by consultants who completed additional research and investigation on their behalf. The consultants are listed in the acknowledgements section of this report.

2 Advisory Group meetings

The Commission met with three advisory groups, consisting of patients and carers, 'early career' staff and an advisory board of senior figures from mental health and social care policy. Membership of these groups is listed in the acknowledgements section below.

3 Service visits

The Commission visited several services throughout the year and spoke to staff, patients and carers. The organisations the Commission visited are listed in the acknowledgements section below.

4 Call for Evidence

From February to April 2015, the Commission issued a 'Call for Evidence' focusing on the value, purpose, and current state of inpatient care and services offering alternatives to inpatient care within community settings. The Commission specifically asked for examples of good and poor practice, and recommendations for improvement. The Call for Evidence received 162 completed responses, of which 23 were from Northern Ireland. These included responses from people with lived or clinical experience, as well as submissions from organisations such as the Law Centre (NI), the Royal College of Nursing and the Health and Social Care Board (HSCB).

5 Survey of acute psychiatric wards

The Commission surveyed acute psychiatric wards in Northern Ireland between Wednesday 20th April and Friday 6th May 2016. PICU wards and older adult psychiatric wards were excluded, except in cases where wards provided mixed provision with acute beds and PICU/older adult psychiatric beds. Responses were received from 16 acute psychiatric wards, representing 100% of acute psychiatric wards in the region. 12 of the responses were fully completed and 4 responses were partially completed. As part of the survey responses, non-identifiable patient level data was collected on 219 patients.

6 Stakeholder meetings

The Commission held stakeholder meetings with representatives from various stakeholder groups in September 2015 and May 2016. The organisations represented are listed in acknowledgements section below.

Acknowledgements

The members of the Commission would like to thank everyone who has contributed to its work over the past year, particularly those who responded to its Call for Evidence.

In addition, the Commission is extremely grateful to the following organisations and individuals for the support they have offered the Commission in various forms:

Advisory Groups

The membership of the Commission's advisory groups was as follows:

Advisory Board

Stephen Chandler

Joint Chair of Mental Health Network, ADASS

Stephen Dalton

Chief Executive, Mental Health Network,
NHS Confederation

Dr Michael McBride

Chief Medical Officer Northern Ireland, Department
of Health, Social Services and Public Safety

Anne McDonald

Deputy Director, Armed Forces and Offender Health
and Mental Health Legislation, Department of Health

Dr Geraldine Strathdee

National Clinical Director Mental Health, NHS England

Service User and Carer Advisory Group

Richard Birch

Ian Carmichael

Junaid Iqbal

Dr Martin Lee

Sharon Magorrian

Frances Reid

Christine Ritchie

Jake Roberts

Tina Savage

Rachel Vowles

Early Career Professionals Advisory Group

Dr Niall Corrigan

Dr Selma Ebrahim

Dr David Fewtrell

Becky Hoskins

Rob Manchester

Sheila Messider

Dr Ashish Rana

Gemma Rhodes

Dr Jane Shears

Dr Rumina Taylor

Dr Sophie Tomlin

Dr Claire Williams

The following organisations also helped the Commission recruit members to its advisory groups: The British Association of Social Workers (BASW), British Psychological Society (BPS), CAUSE, Hafal, Rethink, the Royal College of Nursing (RCN) and the RCPsych Service User and Carer Fora.

Site visits

The following organisations hosted visits by members of the Commission and allowed members of the Commission to visit services and speak with patients, carers and staff.

- Belfast Health and Social Care Trust
- Northern Health and Social Care Trust

The Royal College of Psychiatrists

The Commission was supported by the Royal College of Psychiatrists and is very grateful for the ongoing support and guidance provided by Dr Ranga Rao, College Lead for the Commission and Dr Mary-Jane Tacchi, the College Specialist Adviser for Crisis Care. The Commission is also grateful for the support from:

- The Chair of RCPsych in Northern Ireland, Dr Gerry Lynch and the former Chair Dr Diana Day-Cody
- The staff in the RCPsych in Northern Ireland, Nora McNairney, Thomas McKeever and Michelle Newell
- Dr Margaret du Feu and Dr Peter Trimble on behalf of the RCPsych in Northern Ireland Executive Committee
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- The RCPsych's Strategic Communications Department, in particular Kim Catcheside, Kathryn Stillman and Claire McLoughlin
- The RCPsych's Policy Unit, in particular Greg Smith, Krista Nicholson, Chris Fitch and Lucy Thorpe

Survey

The Commission is extremely grateful for the support of the trainee and staff grade psychiatrists who facilitated the Commission's survey of acute psychiatric wards in the region. The trainee psychiatrists involved were:

- Dr David Bell
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- Dr Christine Fitch
- Dr Catherine Gillanders
- Dr Maggie Kelly
- Dr Deborah Miller
- Dr Oonagh Murphy
- Dr Gabrielle O'Hagan
- Dr Simon Patterson
- Dr Stephanie Redpath
- Dr Bronagh Sproule
- Dr Faye Tierney
- Dr Keira Walsh

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- Dr Joseph McKane
- Dr Stephen Moore
- Dr Michael Nicholson
- Dr Derek Robinson
- Dr Rachel Symlie
- Dr Aidan Turkington
- Dr Mairin Walsh

Additional Evidence and Support

The following organisations and individuals provided additional evidence or support to the Commission's work or who attended the Commission's stakeholder meetings:

Organisations

- Bamford Monitoring Group
- Belfast Health and Social Care Trust
- Department of Health Social Services and Public Safety
- Health and Social Care Board
- Northern Health and Social Care Trust
- Patient and Client Council
- Public Health Agency
- Regulation and Quality Improvement Authority
- South Eastern Health and Social Care Trust
- Southern Health and Social Care Trust
- Western Health and Social Care Trust

Individuals

- Lord John Alderdice
- Don Bradley
- Damien Brannigan
- Dr Neta Chada
- Patrick Convery
- Oscar Daly
- Eithne Darragh

- Andrew Dawson
- Pedro Delgado
- Oscar Donnelly
- Maire Grattan
- Maeve Hully
- Molly Kane
- Chris Mathews
- Dr May McCann
- Paul McFall
- Dr Deirdre McGlennon
- Dr Johnny McMahon
- Dr Ian McMaster
- Bryce McMurray
- Barney McNeany
- Rodney Morton
- Aidan Murray
- Dr Maria O'Kane
- Dr Tony O'Neill
- Dr Nial Quigley
- Adrian Walsh

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The Commission
to review the
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inpatient psychiatric
care for adults

More information
about the Commission
is available at
www.caapc.info