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

OLD PROBLEMS, NEW SOLUTIONS:
Improving acute psychiatric care for adults in England

FINAL REPORT

FEBRUARY 2016

Old Problems, New Solutions: Improving Acute Psychiatric Care for Adults in England

Independence, funding and disclosure of interests

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Foreword from the members of the Commission

Urgent action is needed to improve acute psychiatric care for severely ill adult mental health patients in England.

Our report describes widespread problems with finding beds or receiving good home treatment but it also points to the improvements that can be made and gives examples where people are being well cared for in good services.

These are old problems but there are new solutions for improvement thanks to experience and learning in recent years, new technology and – very importantly – the commitment of all political parties to achieving parity between mental and physical health. This opportunity needs to be grasped.

The Commission's focus has been only on acute care for adults but it has linked with the much wider review undertaken by the NHS England Mental Health Taskforce – the Chair and Vice-Chair of which have been members of this Commission. We very strongly welcome their proposal for new investment in Crisis Resolution and Home Treatment teams and believe that our recommendations will support the Taskforce's strategy.

Government has important responsibilities here but so too do local organisations and leaders. Government needs to set direction, create the policy framework and secure adequate funding, while local people will need to exercise judgement and make decisions within their local context taking account of the available resources and capabilities. Both local and national leaders have the important responsibility to help change the way mental illness is perceived and to create the relationships and culture which will ensure that people receive the high quality, respectful and compassionate care they need.

We are all very grateful to the people we met or who wrote to us to tell us of their experience or offer us advice. We were both very depressed by some of what we heard and, on the other hand, deeply impressed by the care, commitment and expertise we saw in some services. We are particularly grateful to the patients, carers, policy makers and practitioners who joined our advisory groups.

The is an independent Commission but we have been very well supported by the Royal College of Psychiatrists through its Policy Unit and are, in particular, very grateful to Greg Smith and Krista Nicholson for so ably undertaking research and providing administrative support to the Commission.

Lord Nigel Crisp
on behalf of the members of the Commission

Key points

Access to acute care for severely ill adult mental health patients is inadequate nationally and, in some cases, potentially dangerous. There are major problems both in admissions to psychiatric wards and in providing alternative care and treatment in the community. These two sets of problems are intimately connected and need to be tackled together.

There are, nevertheless, many good services around the country and enormous scope for dramatically improving others. These are old problems but there is a great deal to build on and new opportunities for innovation.

The Commission's starting point is that patients with mental health problems should have the same rapid access to high quality care as patients with physical health problems. It proposes the introduction of firm targets for improvement combined with new approaches to quality, data management, innovation and investment.

The Commission recommends that:

1 A new waiting time pledge is included in the NHS Constitution from October 2017 of a maximum four-hour wait for admission to an acute psychiatric ward for adults or acceptance for home-based treatment following assessment.

2 The practice of sending acutely ill patients long distances for non-specialist treatment is phased out by October 2017.

3 Commissioners, providers and clinical networks in each area together undertake a *service capacity assessment and improvement programme* to ensure that they have an appropriate number of beds as well as sufficient resources in their Crisis Resolution and Home Treatment teams to meet the need for rapid access to high quality care by October 2017.

4 Service providers, commissioners and Health and Wellbeing Boards work together to improve the way the mental health system works locally – sharing information, simplifying structures where appropriate, and finding innovative ways to share resources and deliver services.

5 There is better access to a mix of types of housing – and greater flexibility in its use – to provide for short-term use in crises, reduce delayed discharges from inpatient services and offer long-term accommodation.

6 A single set of easy to understand and measurable quality standards for acute psychiatric wards is developed nationally with the involvement of patients and carers and widely promoted and communicated.

7 The growing awareness and use of quality improvement methodologies in mental health is nurtured and accelerated.

8 Patients and carers are enabled to play an even greater role in their own care as well as in service design, provision, monitoring and governance.

9 A *Patients and Carers Race Equality Standard* is piloted in mental health alongside other efforts to improve the experience of care for people from Black and Minority Ethnic communities.

10 The collection, quality and use of data is radically improved so it can be used to improve services and efficiency, ensure evidence-based care is delivered and improve accountability.

11 All mental health organisations promote leadership development and an open and compassionate culture with particular reference to better ward management, values-based recruitment, and staff training and development.

12 Greater financial transparency, removal of perverse incentives and the reduction of waste is coupled with investment in the priority areas identified here – acute care capacity, housing, information systems and staff – and guarantees about financial parity with physical health.

This report paints a picture of an acute mental health system under pressure, with difficulties in access to care compounded by – in some instances – poor quality of care, inadequate staffing and low morale. Too often inadequate data and information are available but it is clear that the whole system has suffered from a steady attrition in funding from both NHS and local government sources in recent years.

National and local government need to act to redress the balance and ensure that mental health receives equal priority and funding with physical health. Commissioners and providers, too, have a responsibility to lead change, focus on quality and improve the way their organisations and the whole system works.

Most of what is needed is already being done somewhere in the country with committed and innovative people – patients and carers as well as professionals – working hard to improve services. This report's recommendations are designed to get behind their efforts and help them to share their learning and achieve their ambitions.

Glossary

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.

Approved Mental Health Professional (AMHP)
An AMHP is a social worker or other professional approved by a Local Authority to carry out a variety of functions under the Mental Health Act.

Assertive Outreach Team (AOT)
Assertive Outreach Teams are specialist mental health services. They may be part of a community mental health team, or may be separate. They work with people who are over 18 years old who have complex needs and need more intensive support.

Care Programme Approach (CPA)
The CPA is the national system setting out how secondary mental health services should help people with mental illnesses and complex needs. Under the CPA, care is co-ordinated by a "Care Co-ordinator", who is usually a community psychiatric nurse, social worker or occupational therapist.

Community Mental Health Team (CMHT)
CMHTs are a secondary mental health service which provide support to people living in the community who have complex or serious mental health problems.

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.

Early Intervention in Psychosis (EIP) team
EIP teams work with people experiencing their first episode of psychosis.

Improving Access to Psychological Therapies (IAPT)
IAPT is an NHS programme providing NICE-approved interventions for treating people with mild to moderate depression and anxiety disorders across England.

Liaison Psychiatry
Liaison Psychiatry services provide immediate access to specialist mental health support for people being treated for physical health problems, most often in general hospitals (including Accident and Emergency departments) and in some cases in the community.

Mental Health Act (MHA)
The Mental Health Act 1983 (amended in 2007) is the law in England and Wales that allows people with a 'mental disorder' to be admitted to hospital, detained and treated without their consent – either for their own health and safety, or for the protection of other people.

National Service Framework for Mental Health (NSF)
The National Service Framework for Mental Health was a policy document introduced in 1999 that set out the type and structure of specialised community mental health teams in England.

NHS Constitution
The NHS Constitution sets out the principles and values that guide how the NHS should act and make decisions. It also explains the rights and responsibilities of staff, patients and the public, and the NHS' pledges to them.

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.

Psychiatric Intensive Care Unit (PICU)
A PICU is a type of psychiatric inpatient ward for emergency short-term care and treatment for mental illness. They are designed to offer a higher level of support and supervision than on acute inpatient wards.

Street Triage
Street Triage is an ongoing Department of Health initiative, which sees police and mental health services work together to ensure people receive appropriate care when police are called to assist a person experiencing a mental health crisis.

Organisations and groups

Care Quality Commission (CQC)
The CQC is the independent regulator of health and social care services in England. They monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety.

Clinical Commissioning Groups (CCGs)
Clinical Commissioning Groups are clinically-led NHS bodies responsible for assessing local needs, and for planning and commissioning health care services for their local area.

Health and Social Care Information Centre (HSCIC)
The HSCIC is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

Health and Wellbeing Boards
Health and Wellbeing Boards are composed of key leaders from the health and care system, who work with Clinical Commissioning Groups and Local Authorities to improve the health and wellbeing of their local population and reduce health inequalities. They have responsibility for the oversight of services in their area and for enabling partnership working between organisations.

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.

NHS Confederation
The NHS Confederation is a membership body that brings together and speaks on behalf of all organisations that plan, commission and provide NHS services.

NHS England
NHS England leads the NHS in England, overseeing the commissioning of health care services. They also provide certain types of highly specialist health care, including some specialised mental health services.

NHS Improvement
NHS Improvement is a new regulator for NHS providers. It was formed by the merger of Monitor and the Trust Development Authority (TDA).

NHS Providers
NHS Providers is the membership organisation and trade association for NHS acute, ambulance, community and mental health services that treat patients and patients in the NHS.

Acute Trusts
Acute Trusts are NHS organisations that provide health care services for people with acute physical health needs.

Mental health Trusts
Mental health Trusts are NHS organisations that provide mental health care for people with mental health problems or learning disabilities.

Royal College of Nursing (RCN)
The RCN is a trade union and membership organisation for registered nurses, midwives, health care assistants and nursing students. As a professional body it carries out work on nursing standards, education and practice.

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.

Strategic Clinical Networks (SCNs)
Strategic Clinical Networks bring together providers, commissioners and patients to drive quality improvement and patient outcomes in specific areas of health care. There are currently four types of national SCN, including one for Mental Health, Dementia and Neurological Conditions.

01

Introduction

Summary

This chapter sets out the Commission's purpose and approach, describes the problem of access to acute care that it addresses and outlines the structure of the report.

The chapter shows that access to acute care for severely ill adult mental health patients in England is inadequate and, in some cases, potentially dangerous. There are major problems both in admissions to psychiatric wards and in providing alternative care and treatment in the community. These two sets of problems are intimately connected and need to be tackled together.

The Commission has worked on the basis that patients with mental health problems should be treated equally to patients with physical health problems. It therefore recommends that a new waiting time pledge is included in the NHS Constitution from October 2017 of a maximum four-hour wait for admission or acceptance for home based treatment following assessment. It also recommends that the practice of sending acutely ill patients long distances for non-specialist treatment is phased out by October 2017.

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 and recommend ways of improving the service.[*]

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 was asked to address acute care for adults only and has not therefore looked at specialist services or those for children and adolescents – except where they impact on acute adult services.

The Commission did, however, recognise from the start that this is a systems issue and that acute adult inpatient services cannot be treated in isolation from everything else – and that making changes in one part of the system will affect everything else. In particular, admissions need to be addressed alongside the provision of alternative services by Crisis Resolution and Home Treatment teams (CRHTs).[**]

The Commission has approached its task in a consultative and inclusive way. It established three advisory groups, created working groups to look at particular areas, issued a Call for Evidence, visited services and met many people from different backgrounds as shown in Appendix 2.

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[*] See Appendix 1 for the terms of reference, membership of the Commission and its methodology

[**] In most of the country Crisis Resolution and Home Treatment teams are joined together into a single unit but they are separated or given different names in some areas. This report refers to them generically as CRHT teams unless the reference is to one or the other.

Members of the Commission understand very well that there have been many reviews, reports and recommendations about mental health in recent years – and that many people working in the field will be weary of investigations, initiatives and advice. They have therefore tried not to duplicate effort and have chosen to make relatively few recommendations which, wherever possible, build on existing processes and good practice. In particular they have been conscious of the need to liaise closely with the work of the NHS England Mental Health Taskforce which is reviewing the whole field of mental health – a relationship made easier because the Chair and Vice Chair of the Taskforce were also members of this Commission.

The report concentrates on solutions rather than just problems and contains many examples where Trusts have very successfully improved their admission (and other) processes and the quality of their services. 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 problem – access to high quality acute psychiatric care

The problem the Commission was set up to address is that patients in England who require acute 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.

Current estimates suggest that each month around 500 mentally ill people have to travel over 50km to be admitted into hospitals far from their own homes.[1] These long distance admissions are mainly due to difficulties in finding acute inpatient beds or suitable alternative services in their home area[2] and are a symptom of far more widespread problems in the functioning of the whole mental health system.

These system-wide problems which affect how acute care is delivered are described in later chapters and summarised in Box 1.

This long list of problems shows that solutions must involve significant change in how services are commissioned, organised and monitored across the whole system. These solutions will require implementation by many different people and organisations.

The historical context is that, as Figure 1 shows, beds across the whole mental health sector have decreased as more care has been transferred to the community. Bed numbers fell by 62% between 1987/88 and 2009/10. Data is not routinely collected for numbers of acute adult beds only but latest figures from NHS Benchmarking for March 2015 indicate that there are 6,144 acute adult NHS beds in England, down 3.7% on the year before.[3] Figure 2 shows how admissions have stayed broadly level over a 10 year period whilst the numbers of people using community services have increased significantly. This figure shows a significant upward movement between 2010/11 and 2011/12 due to changes in the way the data are collected. Leaving this aside, the overall upward trend is still clear.

This reduction in bed numbers reflects the long-term policy of providing more care in the community. 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.

Box 1: System-wide problems in provision of adult mental health services

A Inadequate availability of inpatient care or alternatives to inpatient admission when needed.

B Many patients remain in inpatient beds for longer than is necessary in significant part because of inadequate residential provision out of hospital.

C Variable quality of care in inpatient units, reflecting the environment, the interventions available and the number and skills of health and care workers.

D Variation in terms of access to evidence-based therapies across the entire acute care pathway.

E A lack of clarity as to the quality outcomes expected and how these should be reported in a transparent way.

F Variable involvement of patients and their carers in both the care received and in the organisation of services.

G Significant differences in the quality of leadership and the culture of organisations.

H A fragmented approach to the provision of the commissioning of services providing inpatient care.

Figure 1: Number of beds available across the mental health sector between 1987/88 and Q1 2015/16
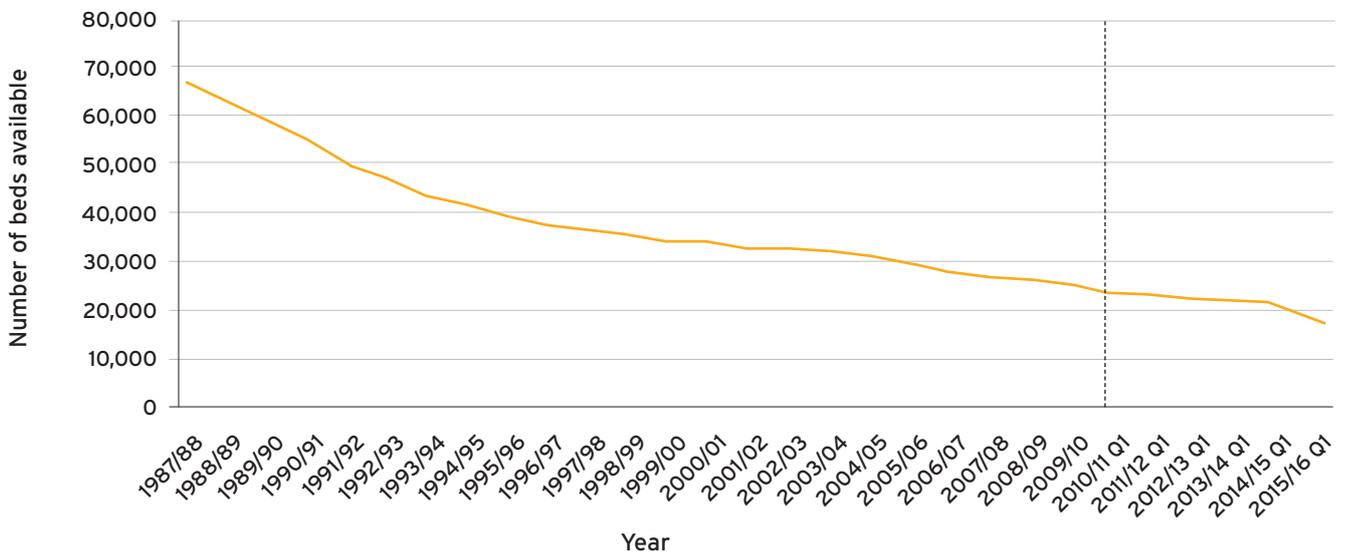
Data source: NHS England bed availability and occupancy data – overnight.
The dataset changed between 2009/10 and 2010/11 and moved to a quarterly collection period.
This means data may not be directly comparable with previous years.

Figure 2: The number of people in contact with mental health services (adult and older adult) by highest level of care between 2003/04 and 2013/14
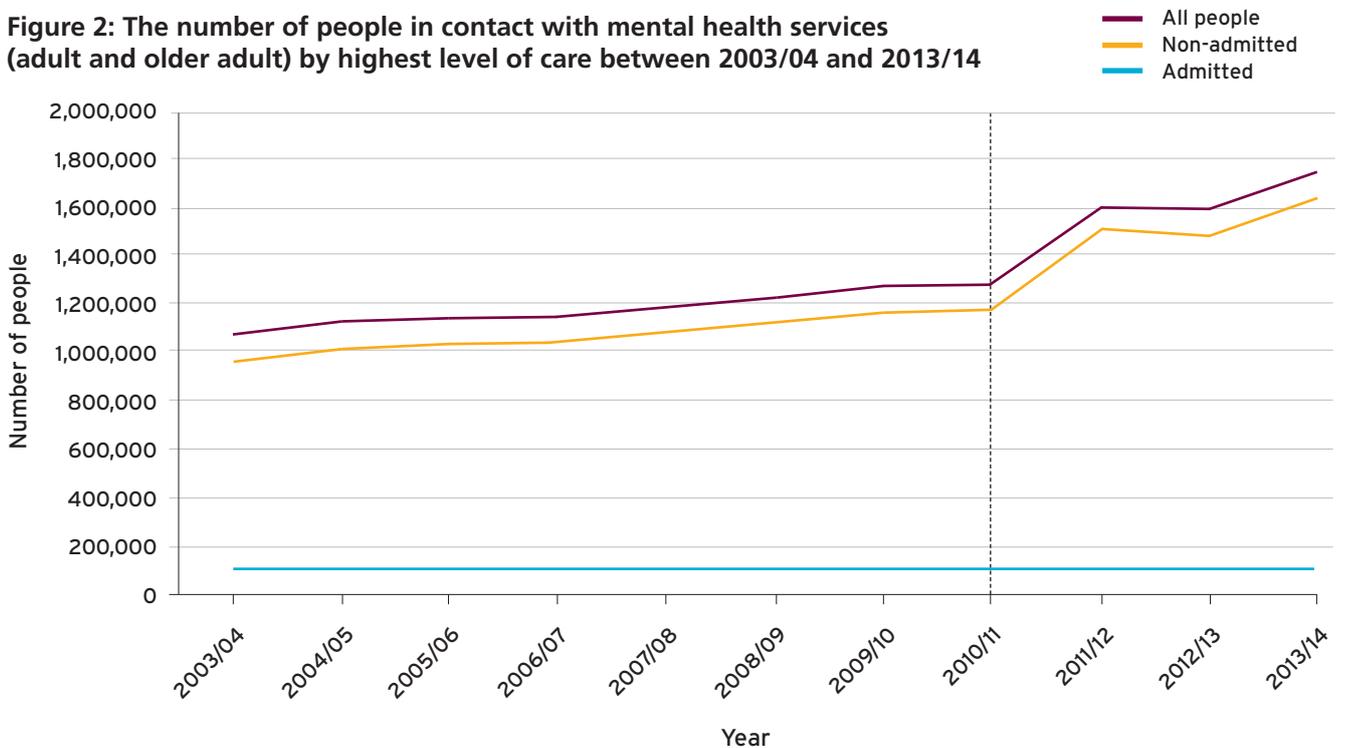
Data source: HSCIC, Mental Health Bulletin, Annual Report – 2013-14, national reference tables.
Note: The dataset changed significantly between 2010/11 and 2011/12, meaning data is not directly comparable with previous years. The dataset also included submissions from independent sector providers for the first time in 2010/11.

Mental health services are immensely important. In 2013/14 1.7 million people in England used mental health services – with 105,270 admitted to hospital[4] – and their families, friends and many others were affected by their illness. As of 2011/12 NHS spend on adult mental health services in England was £6.629 billion. This is rather more than half of the total NHS spend of £11.16 billion on mental health services for all ages and represents 6.3% of the total English health budget that year.[5] The indirect cost of mental illness, including time lost from work or education, is very much higher. 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 discussed here are not new. The National Service Framework for Mental Health (NSF) published in 1999 described them in almost identical fashion[6] and, while the NSF led to many improvements, particularly in community services, problems with accessing acute inpatient services remain. These problems are not universal, and affect different areas in different ways and to different extents. 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 Commission was told of problems with admissions by patients and their carers, NHS and other staff, police officers, commissioners of services, voluntary organisations and Trust Boards. The most common problem was difficulty in finding a bed but there were also concerns from patients and carers about the quality of the process – with many carers complaining about being excluded – and about the risks to patients and the public if someone needing inpatient care is not admitted where home based treatment is not possible or appropriate.

The situation has become more pressurised in recent years as the continuing decline in bed numbers has been accompanied by increased occupancy of wards[7] and problems of discharge.[8] As a result, many services have raised their threshold for admission meaning that it is harder for patients to get admitted. The level of acuity of patients on many wards has increased as a result of this, as only the most unwell or those presenting the greatest risk are admitted.[9]

There is no record of the number or proportion of patients who face these sorts of difficulties or of the length of time that an admission takes. However, the Commission was told that crisis bed management is a daily occurrence in some Trusts with staff trying to free up beds by moving patients from ward to ward, sending them home on leave or discharging some earlier than had been planned into alternative accommodation or their own homes.

The following quotations from a patient and a clinician are typical examples of the sort of problems described to the Commission.

> **Patient: I returned to hospital from leave but there were no beds available so I had to sleep in a common room. There was little privacy – no lock on the door, no frosted glass, people often just wandered in thinking it was a public room and I had to create my own make-shift curtains. The room stank of cigarettes, the floor was dirty and the only storage space I had was a small bedside table. Despite constant complaints from me regarding the room I was expected to put up and shut up - I would have had better accommodation in jail!!!!"**

> **Clinician: In the past month, bed occupancy peaked at 150% for my ward and has not been lower than 125%. I almost always have at least one patient sleeping over on other wards and sometimes there are no beds available at all in our Trust and surrounding hospitals (NHS and private). If a patient goes on leave for even one night they lose their bed as it is immediately filled. My inpatient caseload will also regularly include patients who are in the community, partly because the community service lacks sufficient care co-ordinators who can respond quickly to taking on new referrals."**

The Care Quality Commission's 2014/15 Mental Health: State of Care report found that in one Trust there were 68 occasions in the first two months of 2015 when a bed was either not available to patients or there were delays in a patient receiving a bed. In the same Trust there were 57 occasions in a three-month period where patients did not have a bed to sleep in and slept on the sofa or in the quiet room on a temporary bed, and 85 occasions across the acute wards where patients slept on a ward other than the one they were admitted onto. It reported that *"some patients were transferred during the night… Patients told us that when they refused to move they were accommodated on sofas on the wards."*[10]

An indication of the scale of the problem is given by the number of people who have to travel long distances for admission for services which ought to be available close to home. Provisional figures from the Health and Social Care Information Centre, as noted earlier, show that in September 2015 499 adults had to travel more than 50 kilometres, or just over 30 miles, for admission to a service which should be provided locally, such as acute care, psychiatric intensive care or rehabilitation services.[11]

Whilst some of these journeys will be in rural areas where 50 kilometres may not be unusual, this figure suggests that significant numbers of people – certainly thousands each year – are travelling unacceptably long distances for acute admissions. This data also reveals that there is a great deal of variation between areas: some have a lot of long-distance admissions whilst others have very few.

Out of area treatments cause 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 well spend longer as inpatients than they would have done if admitted locally. The number of suicides after discharge from a non-local unit has increased in recent years, from 68 between 2003 and 2007 to 109 between 2008 and 2012 leading the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness to call for an end to acute admissions out of area.[12]

These placements are also very expensive. There are no national figures available but, by way of example, the Commission learned that one Trust had spent £4.8 million on out of area treatments for up to 70 patients at any

one time in 2013/14 – at an average cost of approaching £150,000 per patient per annum. It has subsequently reduced numbers and consequently costs to an estimated £1.2 million in the current year.

Problems are not confined to admissions and inpatient services but are also evident in some CRHT services which provide alternatives to hospital admissions. Clinicians make frequent risk assessments in deciding how best their patients can be treated. Every year some patients (whom services have decided not to admit) harm themselves or others – as do some people shortly after their discharge. The 2015 report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that whilst numbers of suicides by inpatients have been falling in England, the number of suicides by patients under the care of CRHT teams is increasing and there are now three times as many suicides under CRHT care as in inpatient care. In 37% of cases the patient had been under the care of the CRHT for less than a week.[13] Risks have been transferred from one part of the system to another. This puts great importance on ensuring that CRHTs are able to operate effectively as intensive specialist community-based alternatives to inpatient care and not simply as generic crisis services.

The National Confidential Inquiry says that its findings *"may reflect reduced availability of local inpatient beds, with increasing reliance on home treatment as an alternative to admission, and on beds that are out of the local area."*[14] As well as arguing for an end to out of area admissions, it calls for the monitoring of CRHT services to ensure they are being used safely, stating they should not be used by default for patients who are at high risk or who lack other social supports and skills and that contact time within CRHTs should reflect the intensive and specialised nature of the role.[15]

These problems do not just affect healthcare staff but impact on a whole range of different people including the police as the examples in Box 2 show. These two examples are based on real life events.

While the Commission's main focus is on access to acute care, this is not, of course, the only quality issue affecting severely ill mental health patients and their carers. As will be seen in future chapters, there are problems in providing quality of care in inpatient and community settings as well as wonderful examples of effective and high quality care in both.

Box 2: The police experience of the risks associated with access to inpatient care

Example 1

Officers were asked to attend a location to meet an Approved Mental Health Professional (AMHP) who had a Section 135(1) warrant and who wished to undertake a Mental Health Act (MHA) assessment. The individual concerned had a significant history of violence, so the police despatched a sergeant and several officers with specialist training and protective equipment. Upon arrival, they met the AMHP who checked that a bed which had previous been identified was still available. On being told it wasn't, the AMHP postponed the MHA assessment.

Several hours later the police were called to a stabbing where the patient had randomly attacked a stranger. The patient was subsequently prosecuted for attempted murder.

Example 2

The police may hold someone under arrest for a criminal allegation for up to 24hrs before they must charge or release them. If a decision is taken to assess someone under the Mental Health Act and subsequently to admit them to hospital, they must be released from police custody as soon as the decision is taken not to prosecute. Where delays are encountered in securing a relevant admission bed it can give rise to illegal detention where AMHPs are prevented from complying with their duties under the Act before the custody sergeant's obligation to release.

The Commission has been told that incidents of illegal detention resulting from unavailability of an inpatient bed are not infrequent. However, it understands that no data are collected on a national level about this, and that data at local level are only collected by a small minority of police forces. The collection of such data could be a valuable tool in assessing whether the provision of inpatient beds in an area is adequate.

The structure of the report

The report's structure reflects the systemic nature of the problems described here:

- Chapter 2 describes the purpose of inpatient care and its relationship with CRHT within the acute care pathway.
- Chapter 3 discusses the wider mental health system and how poor coordination, difficulties in working across organisational boundaries and weak commissioning all contribute to the problems.
- Chapter 4 examines quality and safety.
- Chapter 5 looks in more detail at the experience of patients and carers.
- Chapter 6 describes the major problems with access to reliable data both for operational purposes and for accountability.
- Chapter 7 focuses on leadership, culture and staffing.
- Chapter 8 addresses finance and resources.
- Chapter 9 draws out some overarching conclusions, offers a brief discussion of future directions and possibilities and lists all 12 recommendations.

Recommendations

The problems of access described here affect the whole mental health system for adults and need to be addressed urgently. As has been described earlier, this level of impact on patients, carers and the public would not be tolerated for patients with physical health needs.

Government needs to give tackling these problems a high priority and service providers and commissioners need to act now to stop any further out of area acute admissions and begin to tackle the wider service problems. There is evidence that that this can be done – and good examples where organisations have made significant improvements or eliminated out of area transfers altogether. The Commission recognises the scale of the challenge but is greatly encouraged by the ambition and determination of leaders in different parts of the country who recognise that the current situation is unacceptable and are working to make improvements.

The Commission's first recommendations are very simply that Government, commissioners and service providers need to commit themselves to find solutions to these long-standing problems. There needs to be a new waiting time pledge, modelled on those for physical care[16], and a new target to eliminate inappropriate out of area treatments.

The first recommendation treats waiting for admission or access to care by a CRHT in the same way. Both should be started within four hours of assessment. There will need to be some attention to definitions here to ensure both that assessment is not unnecessarily prolonged and that acceptance for home-based treatment means that the actual treatment will start at the appropriate time clinically – recognising that this may vary from patient to patient.

The starting point for defining what constitutes an inappropriate out of area treatment should reflect the government's ambition (as most recently expressed in their Mandate to NHS England for 2016/17) for mental health to have parity of esteem with physical health.[17] In practice, this means that a psychiatric patient should be treated in their Trust's NHS service, and the distance they travel for this service should not exceed the average distance travelled in that Trust for comparable acute adult inpatient physical healthcare. The Commission notes however that there may be circumstances when it is appropriate for a patient to be treated out of area, such as when this is the patient's choice or when safeguarding concerns are relevant.

This is a systems problem. It will simply not be possible to make wider improvements in the whole mental health system unless these out of area treatments are eliminated and acute care improved. Similarly, improvements in these areas won't be sustained unless other parts of the system are re-designed in order to support it. The recommendations in the following chapters each deal with different aspects of the system and show how they can support these improvements.

The Commission recommends that:

1   A new waiting time pledge is included in the NHS Constitution from October 2017 of a maximum four-hour wait for admission to an acute psychiatric ward for adults or acceptance for home-based treatment following assessment.

This will involve:

- NHS England and NHS Improvement establishing the definitions and arrangements needed for measurement and data collection and adding this pledge to planning and monitoring processes and performance announcements.

- Trusts and other providers working with their commissioners to establish local arrangements for data collection and local publication of results.

2   The practice of sending acutely ill patients long distances for non-specialist treatment is phased out nationally by October 2017.

This will involve:

- NHS England and NHS Improvement introducing a target for halving current levels of out of area treatments for acute adult inpatient care by April 2017 and their total elimination by October 2017.

- NHS England and NHS Improvement holding both commissioners and providers to account for achieving this target.

- NHS England and NHS Improvement establishing a national reporting system for monitoring the number, nature and causes of out of area treatments by July 2016, publishing a complete national baseline picture by September 2016.

- Commissioners and providers working together with patients' and carers' groups locally to agree what constitutes an out of area transfer in their locality within the national framework and definitions provided by NHS England and NHS Improvement.

- The Care Quality Commission changing its inspection framework in response to both this and Recommendation 1 so that unacceptable distance travelled is measured along with unacceptable waiting times in judging whether a service is responsive to local needs.

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02

The purpose and capacity of acute adult inpatient care

Summary

This chapter directly addresses two parts of the Commission's terms of reference:

• Describe the purpose and value of inpatient care as part of the wider system.

• Propose how to identify the size and scope of safe and therapeutic inpatient services.

In doing so it emphasises the links between inpatient services and Crisis Resolution and Home Treatment teams within acute care and, more generally, the importance of seeing inpatient services as part of the whole system of mental healthcare.

It recommends that commissioners, providers and clinical networks in each area together undertake a *service capacity assessment and improvement programme* to ensure that they have an appropriate number of beds as well as sufficient resources in their Crisis Resolution and Home Treatment teams to meet the need for rapid access to high quality care by October 2017.

The acute care pathway

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

An example of what a 'good' acute pathway would look like, taken from guidance published by the Joint Commissioning Panel for Mental Health, is shown in Figure 1. Successful implementation of this pathway depends, as can be seen from Figure 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 country 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.

This variability in the pathway is accompanied by big differences in the numbers and use of beds and the amount of money spent on inpatient and other services. Between English Trusts, acute bed numbers range from 7.8/100,000 weighted population to 32.4/100,000 weighted population with a mean of 19.4 and a median value of 19.3.[2] Mean length of stay (excluding leave, unadjusted for outliers) varies from 12 days to 55.5 days with a mean of 33.2.[3] Similarly, there is a great deal of variation in the number and type of services provided in the community. Moreover, whilst some Trusts have no out of area treatments, the highest user had sent 446 patients out of area in one year.[4]

There is even more reported variation in expenditure. It is recorded that Trust expenditure on adult acute inpatient beds in 2014/15 (per 100,000 weighted population) varied from £863,467 to £4,109,421.[5] However, this level of variation suggests that this is not comparing like with like and that accounting practices and definitions are not consistent. This is an example of the system-wide problem in obtaining accurate data on mental health which the Commission encountered throughout its work and which is the subject of Recommendation 10 in Chapter 6.

Bearing in mind this problem with data, there does not appear to be any correlation between either bed numbers or expenditure with out of area treatments and other indicators of quality. However, as one might expect, many people told the Commission that there is a relationship between the strength of community services and reduced pressure on inpatient services and fewer out of area placements. The Commission heard that the better community services are integrated into the whole system the better their collective ability was likely to be in preventing hospital admission in the first place and discharging patients more quickly.

Reductions in bed numbers appear in some areas to have been accompanied by attrition in services in the community, although it is difficult to identify precise numbers. Anecdotally, part of the recent increases in pressure on inpatient services is seen as coming from cuts in community services and changes in the way these services operate with, for example, Community Psychiatric Nurses carrying very large caseloads and Crisis Resolution and Home Treatment (CRHT) teams only having time for assessment and not for providing community-based treatment.

Figure 1: The acute care pathway[1]

The date and time of the 72hr CPA Review/Formulation Meeting is set at the initial 24hr Report Out. If patient has a care coordinator, or if Crisis Team are to have this role, ward admin contact relevant team, inform them of date and time of CPA Review/Formulation Meeting and request attendance. If patient is not known to services and inpatient MDT request care coordinator to be allocated, ward admin staff to contact relevant community team to hand over request and invite to 72hr CPA Review/Formulation Meeting

The 24hr Report Out is chaired by the nurse in charge or consultant. The Report Out has a task time of 30 mins. Each new admission is allocated no more than 10 mins. A personalised assessment plan and professional involvement in this is defined and traffic light status.

Green: aim of admission/discharge criteria has been met. Regular reviews by medic not required. Ready for discharge, no need for medic review

Amber: aim of admission/discharge criteria has been defined. Action plan in place and progressing. Regular review by medic required. Review by a medic required before discharge

Red: further assessment needed. Aim of admission/discharge criteria to be defined. Regular review by consultant required. Not suitable for discharge

Blue: a 'Blue Star' is used to signal (a) 'Fast track' discharge, involve Crisis Team to agree discharge plan – 48hr timescale or (b) priority for MDT attention (ie. due to complexity, risk etc)

A system-wide issue – delayed discharges and alternatives to inpatient care

The problems with access to acute psychiatric care are not just a reflection of the number of beds but need to be seen as a system-wide issue. Members of the Commission were told that significant numbers of patients were admitted because of a lack of alternatives and many also had their discharges delayed. The Commission therefore undertook an England-wide survey of consultants in charge of acute adult wards in order to understand the problem better. This revealed that in the opinion of the consultants responsible for their care an average of 16% or almost one in six patients could have been treated by other services if they had been available.

The problem of delayed discharges is of equal scale and impact. The Commission's survey shows that on average 16%, almost one in every six patients, was clinically well enough to be discharged but could not be because of other factors. There was enormous variation with the lowest reporting zero delayed discharges whilst three wards reported that this applied to a staggering 38% of their patients.

Each of these problems – the lack of alternatives to admission and delayed discharges – is very significant by itself. The numbers affected, however, cannot simply be combined to give an overall figure for people who do not need to be in inpatient wards as some patients might fit into both categories. Nevertheless, they suggest that in an average ward of 20 patients there might be 3, 4 or 5 people who don't need to be there. In a unit of around 100 beds there might be 15, 20 or 25. This is roughly the equivalent of a standalone ward – representing significant expenditure which could be invested in community alternatives to admission.

These findings are consistent with those from other recent reports which have highlighted the impact of delayed discharges in mental health settings.[6] People working within mental health are well aware of these issues. Many of the Commission's respondents in meetings and in its Call for Evidence felt the number of beds was not the main issue and that any new investment should go into services within the community. This view was by no means unanimous, however, and others considered that there simply were not enough beds in their local area.

Interestingly, just over half the consultants who looked after beds said in the Commission's survey that they either had enough beds (28%) or that they would have enough beds if improvements were made to other services (28%). However, 38% said that more beds were needed, presumably whether there were improvements in community services or not. When asked which factors affected their answer (whatever it was), many respondents drew attention to the availability of housing (39%), the quality of community teams (30%) and the availability of rehabilitation units (16%).

The headline findings from the Commission's survey are shown in Box 1.

Box 1: Findings from the inpatient survey

Survey of Acute Adult Psychiatric Wards
May-July 2015

Methodology

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

Responses

Completed surveys were received from 79% of mental health Trusts. Returned surveys described activity in 122 acute wards – an estimated 27% to 30% of all such wards in England.

Findings

- An average bed occupancy rate of 104% for each ward (range 57%–147%, includes on leave patients).

- 93% of wards operating above the Royal College's recommended 85% occupancy rate.

- On average, 16% of patients per ward could have been treated in an alternative setting. The most common alternative settings named were crisis houses, rehabilitation services and personality disorder services.

- On average, 16% of patients per ward were identified as delayed discharges. The most common causes of delayed discharges were issues with housing, issues transferring patients to rehabilitation services and community team capacity/resources.

- 38% of consultants said that there were not enough beds.

- 28% of consultants said there would be enough beds if improvements were made in other services.

- 28% of consultants said there were enough beds in their local area.

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

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

The Commission's Interim Report developed a working definition of 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.*

The Interim Report 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 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.*

Moreover, as will be seen in Chapter 5, the experience of inpatient care can be very poor for both patients and carers.

This understanding has largely driven the reduction in beds and the development of services seen over recent years in 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 saw 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).[7]

The role and functioning of Crisis Resolution and Home Treatment teams

All Trusts use Home Treatment teams (HTT) or Crisis Resolution and Home Treatment teams (CRHT) as "gatekeepers" for inpatient care, seeking to provide alternative care outside hospital wherever possible. Some Trusts the Commission visited, however, make CRHTs absolutely central to their whole service with in some areas the same team responsible for admissions and discharges. As noted in the first Chapter, there are risks to patients, carers and the public if patients are treated by CRHT teams which are not able to provide adequate, intensive support.[8] Decisions about admission and discharge need to be made with knowledge of the strength and capability of the whole system locally.

It is clearly essential that the composition and capability of CRHTs should reflect the intensive and specialised nature of the role. This requirement is, however, not being met across the country. A recent review of 75 CRHTs measured their performance against best practice and found that average team performance was lower than "good" in all areas measured.33% of teams scored less than "good" in the item on adequate staffing, and 73% scored less than "good" in relation to providing a full multi-disciplinary team.[9] The Commission also notes that there is an extensive study currently underway on how well CRHTs adhere to their intended model of operation and how this impacts service user outcomes.[10]

There are no simple solutions here. A Trust in London which now has the highest ratio of acute home treatment to inpatient care and the lowest acute bed base across London began the redesign of its services in 2008 and has continued development with the same leadership ever since. It serves a population of about 1 million in some of the most deprived communities in London. Its acute bed numbers have fallen from 17 per 100k in 2008 to 10 in 2013. Similarly, older people's bed numbers have fallen from 12 in 2008 to 5 per 100k in 2013. It has a low suicide rate and has not transferred any patients out of its area since commencing the programme in 2008.

Some of the actions it has taken to achieve this are described in Box 2 where it can be seen that it has combined many innovations such as a single point of access and referral with well-resourced and effective HTTs and innovations in

Box 2: Innovations and improvements in access to acute care in North East London

North East London NHS Foundation Trust (NELFT) has redesigned its services extensively including establishing the following:

Access Assessment & Brief Intervention Service

This service offers a single point of access/referrals to all mental health services for adults aged 18 years and over. This is an innovative service delivery model which empowers and enables patients to take an active role in their care process using the principles of recovery. The service provides holistic biopsychosocial assessments with care planning focused on the psychological, physical, social and occupational needs of each individual. The service offers assessment and brief intervention, a Multi-Disciplinary Team (MDT) model of working and treats the spectrum of mental health disorders from advice and primary care liaison to treating severe and enduring psychotic illnesses and managing patients in crisis. Of these referrals only 2% are referred to acute mental health services, and the majority of these patients are treated and discharged back to primary care (70%). This is enabled and facilitated by Access Assessment and Brief Intervention teams having close links to primary and secondary care psychological services, third sector and voluntary organisations as well as community services and local councils.

NELFT's HTTs are an essential component of this integrated model. They act as gatekeepers into inpatient care, and attend daily ward handovers to identify early discharges. This is important as it allows a single point of access to inpatient care (through the HTT) and allows for a reduction in the time spent as an inpatient. The HTT is also involved in all Mental Health Act assessments to ascertain if community care can be provided as an alternative to admission.

This redesign led to reduced demand for acute adult inpatient care. NELFT now provides the highest ratio of acute home treatment to inpatient care and the lowest acute bed base across London.

Philosophy

The philosophy of the model is based on a simple premise. *"What can we do today to make a difference tomorrow?"* This philosophy is also underpinned by a close working relationship between the HTTs and the inpatient wards. This is displayed in the following ways:

Patient flow mechanisms

NELFT has an agreed *"steady state parameter"*. That means a steady bed state that allows planning bed capacity proactively and not reacting to small fluctuations in bed capacity. However, it allows triggering certain actions across the whole system when NELFT is under its steady state parameters but maintains a constant supply of beds.

Weekly patient flow management meetings

The HTTs and inpatient wards meet weekly in MDT patient flow planning meetings. This is when the weekly forecast is made around the movement out and what needs to happen to facilitate those projected discharges. It also provides a space where clinicians can support each other around positive risk-taking.

Daily operations meetings

In addition to the weekly patient flow meetings there are daily inpatient and acute operations group meetings. These look more closely at the daily patient flow using the weekly forecast as a guide for whether patient flow is as planned. The group also looks at patient risk issues, staffing, environment incidents etc. which are all factors that can affect patient flow.

Dedicated inpatient consultants

Each ward has a dedicated consultant which allows for medical continuity and reduced delays around decision-making. NELFT works in the functional split model with dedicated consultants in community teams, HTTs and inpatient wards.

Gatekeeping and early discharge

The NELFT HTTs have a dual function. They act as gatekeepers into inpatient wards, as well as attending daily ward handovers to identify early discharges. This is an important aspect as this allows a single point of access to the bed base (through HTTs alone) and allows for a reduction in unnecessary stays in hospital. The HTTs are also involved in all MHA assessments to ascertain if community care can be provided as an alternative to admission.

Figure 2: The relative costs of beds and other services

1 adult acute bed
= 44 patients on
a CMHT caseload

1 adult acute bed
= 18 patients on an Early Intervention
in Psychosis (EIP) team caseload

1 adult acute bed
= 35 patients on an older adult
CMHT caseload
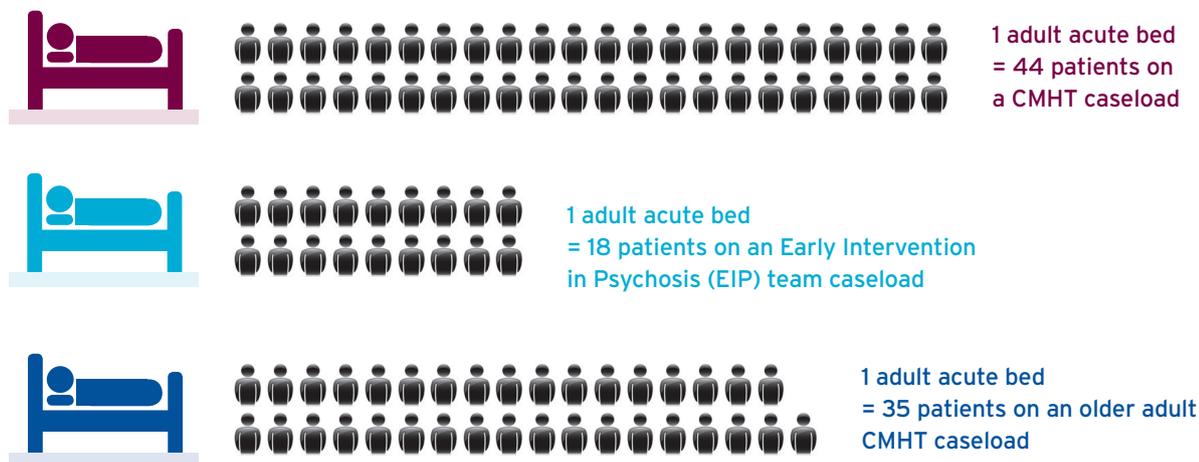
Data source: Information received by the Commission from NHS Benchmarking

the management of beds and patient flows. The activities described here are only part of a wider redesign of services and creation of an integrated mental health pathway.

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. In particular, commissioners and providers in each area need to ensure that:

- they have a shared understanding of the purpose and value of inpatient care and of what this means in practice.

- the different elements of the system are properly resourced with the right people and skills and that they function effectively.

- there is constant monitoring of how well the system is working and of the outcomes, including suicide rates – and adjustments are made to services as necessary.

It is worth noting at this point that there are financial incentives to reduce the size of inpatient services. Figure 2 illustrates the relative costs of beds and other provision. 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 Trust Boards scrutinise all proposals for bed closures with their commissioners and patients and carers groups for risks as well as for financial considerations.

The size and scope of safe and therapeutic services

The Commission was asked 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. Different organisations, like NELFT described in Box 2 and Greater Manchester West Mental Health NHS Foundation Trust in Box 4, have found their own routes to improving services.

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 both allow providers to ensure that they have an appropriately sized inpatient service at any time and to respond as circumstances change.

Service capacity assessment and improvement programme

The approach proposed in this report is very much the same *service capacity and improvement programme* as has been used by a number of mental health Trusts 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 commissioners and patients and carers groups to:

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, 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 bad effects of any interventions – self harm for example – are captured in the measurement system.

4   Make adjustments as necessary.

5   Embed effective interventions into standard work and normal practice.

Chapter 4 contains examples of quality improvement programmes covering whole Trusts or parts of them. Figure 1 on page 66 which deals with incidents of self-harm illustrates the sort of statistical chart that will be needed to identify the base line demand and chart the number of times capacity is exceeded. This monitoring needs to be maintained throughout the improvement process and beyond so that both providers and their commissioners can see how demand for admission is being met.

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, as shown below, from modelling different scenarios using real data.

The National Service Framework for Mental Health Policy Implementation Guide recommended that Acute Care Forums be established within Trusts to:

• Identify the strengths and weaknesses of current local arrangements.

• Stimulate appropriate action.

• Sustain a momentum of change.[11]

Where these are still in operation, they may have a role to play in capacity assessment and service/quality improvement programmes.

The Commission employed a consultancy firm to analyse the findings from six modelling projects they had recently undertaken for Trusts on the adult acute pathway. The total population of the six sites was just over 5 million people and all faced significant pressures.

In their baseline analysis, all six sites were forecast to have regular 'fails' – times when demand exceeded capacity – and regular use of overspill acute beds. Per 1000 total population, the number of expected fails ranged from just over 7 per year to almost 13 per year. Per 100,000 total population, the number of overspill beds (the volume of beds typically required over and above local services) was forecast to range from as low as 1 to as high as 7.5.

The modelling identified a number of mitigating actions, intended to improve the levels of fails and overspill. The extent to which these actions were predicted to improve flow varied from site to site. They did not reduce the predicted fails and overspill to zero; this would have required resource increases well above those which were realistically expected to be available in each case. They did, however, produce substantial expected improvements.

These possible mitigating actions fell into four main groups. They are shown in Box 3 with the actions listed within each group in the order of the frequency with which they arose in the case studies.

This analysis comes from the modelling of results and is reinforced by the real life examples in Boxes 2 and 4. The Commission is aware that many Trusts use some version of this approach to manage capacity and demand. However, it believes that this needs to be done systematically in all areas of the country and that improvement will take time and be achieved through a series of interventions. It therefore recommends that an immediate start on this is needed where this is not already happening,

Another example of a Trust which has critically reviewed and redesigned its acute psychiatric services is shown in Box 4. In this example the Trust combined the strengthening of its CRHT with extending the hours of its Community Mental Health Team (CMHT) into the evenings and the weekends and creating a seven-day telephone helpline for known patients. This example is also interesting in showing the difficulties the Trust encountered in bringing about the changes and the way additional resources were deployed. Most stakeholders seriously under-estimate the difficulty in bringing about change of this type and the dedicated time required.

Box 3: Mitigating actions to improve capacity or reduce demand for inpatient admission

Mitigating actions fell into four main groups. They are listed within each group in the order of the frequency with which they arose in the case studies:

Avoiding admissions
- Greater investment in CRHT teams – diverting resources from other services if necessary.
- Rapid response/crisis services for older people.
- Establishing professional advice lines, for early access to advice for prospective referrers.
- Creating drop-in services open late into the evening for informal support in crises.

Organisation of inpatient services
- Additional local acute beds.
- Beds reorganised according to needs, rather than age or locality.
- More active bed/throughput management.
- Clearer systems for senior clinical decision-making.

Making discharge easier
- More supported accommodation.
- Clearer priority access to community services for people ready for discharge.

Organisation of community services
- Diverting more people with less serious mental health problems to management in primary care.
- Establishing specialist personality disorder services.
- More active management of episode length and throughput within community services.
- Improving the use of time within community teams.
- Providing specialist support for people presenting repeatedly in crisis.
- Combined management of community therapies.

Box 4: Redesign of the care pathway and services by Greater Manchester West Mental Health NHS Foundation Trust

One of the Trust's key observations was that 60% of relatively short inpatient admissions were occurring outside the hours of 9-5 Monday – Friday. The obvious conclusion was not that people were more ill then, but that their community services were not structured or extensive enough to offer the comprehensive service required.

The work to redesign services started from the premise of "what should first class community services look like" rather than "which beds should be shut and where". However, there was also the reality that Cost Improvement Programmes (CIP) are increasingly difficult to achieve with marginal savings so this review also had to reduce costs.

The redesigned Acute Care Pathway offer has therefore delivered the following:

A   CMHTs – previously working Monday-Friday 9am-5pm – now work 8am-8pm Monday-Friday and 9am and 5pm Saturday and Sunday.

B   The Crisis Teams have been redesigned and significantly expanded and have adopted the name of "Home Based Treatment". This multi-disciplinary service works 24/7 and the service is modelled to enable capacity to ensure individuals can receive up to three intensive visits in any 24 hour period. This both avoids admission and accelerates safer discharge.

C   A seven-day telephone helpline has been implemented for "known" patients to enable instant access for talking to a professionally qualified member of staff.

D   Resource issues – the community team developments were "pump-primed" by the provider Trust with non-recurrent resources of just over £1 million. The redesign enabled the closure of 50 beds, which released £3.5 million per annum. Of this, £1.3 million was recurrently reinvested to expand the community services and the remaining £2.2 million was used to support the Trust's CIP. No recurrent or non-recurrent resources were sought from commissioners, just their support for the public consultation required. Despite the local CCG and Local Authority strategic intent to reduce costs and deliver more care closer to home in all specialities, the consultation was difficult. Union negotiations were also extremely challenging, but ultimately delivered. There was a complex redeployment, retraining and recruitment exercise undertaken. There were no compulsory redundancies, with many ward staff choosing actively to "retrain" for the community opportunities.

E   The Trust has also used significant capital to improve the physical environments of the remaining wards and Psychiatric Intensive Care Units (PICUs). It also built purpose-designed Section 136 facilities. The latter had been a contentious and unresolved issue between various commissioners and Acute Trust A&E departments. The mental health Trust has bridged these by offering practical solutions and resources and working in partnership with the police.

F   The Trust is now actively monitoring the increased acuity of patients following these changes and testing its previous assumptions to ensure staffing levels and skills on the acute wards are able to offer safe and therapeutic care.

Strategic Clinical Networks

This discussion highlights a recurring theme throughout this report: that there needs to be much more systematic sharing of best practice and the development of continuous learning systems between organisations in order to accelerate improvement. This might be undertaken through using "Breakthrough Collaboratives" or other quality improvement methodologies. Given that there is no national body able to take on this role, the Commission believes that NHS England's regional Strategic Clinical Networks are well placed to lead programmes of this kind in their area either by themselves or in collaboration with neighbours.

This process will involve many innovations and trials of interventions, only some of which will be successful. It will therefore be important to ensure that evaluations and research are shared and disseminated, whether they are positive or negative. The Commission heard of organisations planning interventions such as the introduction of triage wards without knowing or therefore being able to take account of, recent research that showed that they did not reduce lengths of stay.[12]

Recommendation

Given the need for improved access to acute care and the elimination of out of area treatments by October 2017 the Commission believes it is essential to establish a focused programme of work in each area of the country.

The Commission recommends that:

3 Commissioners, providers and Strategic Clinical Networks in each area together undertake a *service capacity assessment and improvement programme* to ensure that they have an appropriate number of beds as well as sufficient resources in their Crisis Resolution and Home Treatment teams to meet the need for rapid access to high quality care by October 2017.

This will involve:

- Trusts, with the support of their commissioners, using a systematic method, such as the *service capacity assessment and improvement programme* described in this report, to ensure that by October 2017 the acute care service can meet capacity demands in their area.

- Mental health Strategic Clinical Networks establishing a process by October 2016 for the sharing of learning and good practice between organisations in their area.

- Trusts and commissioners providing a quarterly report beginning from October 2016 for Commissioning and Trust Boards and wider public dissemination – and ensuring that remedial action is taken to improve progress where necessary.

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03

The mental health system

Summary

This chapter describes the mental health system and shows how fragmentation of provision and decision-making between many different organisations causes problems for patients, carers and staff and means that some patients are cared for in the wrong setting.

The chapter stresses the importance of systems thinking and shows how some organisations are trying to make the whole system function better and more coherently. It also describes the need for improvements in commissioning, the potential increased service demand from people with learning disabilities and the pressing need for better access to housing.

It recommends that service providers and commissioners work together to improve the way the mental health system works locally – sharing information, simplifying structures where appropriate, and finding innovative ways to share resources and deliver services.

It also recommends that there is better access to a mix of types of housing – and greater flexibility in its use – to provide for short-term use in crises, reduce delayed discharges from inpatient services and offer long-term accommodation.

The mental health system

The discussion in the last chapter showed how access to acute care is intimately linked with other parts of the mental health system. The example of delayed discharges, in particular, revealed the importance of there being efficient linkages between inpatient wards and many different services and organisations providing care and facilities outside hospital.

People with mental health problems are cared for in a range of different services by different providers – including themselves and their own carers in some instances – and the services are paid for in many different ways including by the individual and their family and carers. There are differences, too, in need and provision between rural, urban and metropolitan and inner city 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 or criminal justice have on the lives of people with mental illnesses and their families. It also recognises the importance of understanding how systems work and of systems thinking as described in Box 1.

This approach means that mental health leaders need always to 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 World Health Organization (WHO) and work though the changes in behaviour, processes and systems, measurement, regulation and incentives needed to make and support improvements.

Box 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 don't 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 like NICE, Royal Colleges and academic institutions all influence the operation of the system – for better or worse.

The 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]

It is difficult to provide a simple description or map of mental health services given this complexity. 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 General Practitioner (GP).

- Community services designed to help people maintain their normal roles in society – this would include, for example, Community Mental Health Teams (CMHTs), Assertive Outreach Teams, social housing and supported accommodation, rehabilitation teams, drugs and alcohol teams, voluntary and self-help organisations, and the Improving Access to Psychological Therapies (IAPT) programme which treats people for mild to moderate depression and anxiety disorders.

- Crisis care responding to urgent needs – this includes Crisis Resolution and Home Treatment (CRHT) teams as well as street triage and other programmes.

- Acute inpatient services – which may be in the NHS or in the private sector.

- Specialist inpatient services for mother and baby care, eating disorders, severe personality disorders and forensic services.

As noted earlier the vast majority of mental health patients are cared for in the community with only around 6% spending time as inpatients.[3]

There is overlap between these five groupings and some providers have merged teams and brought services from different levels under the same clinical and organisational management. Patients can move from one level to another – or enter the system for the first time – as an emergency perhaps via Accident and Emergency services or via contact with the police, by referral or through an access service designed to manage access efficiently and consistently.

Whatever the location, however, there is considerable complexity and fragmentation of services as shown in Figure 1 which gives an outline of the main contributors to service provision and decision-making about mental health services in Devon. Different areas would provide a different picture but all would illustrate the need for working across many boundaries between organisations which have their own priorities and organisational needs.
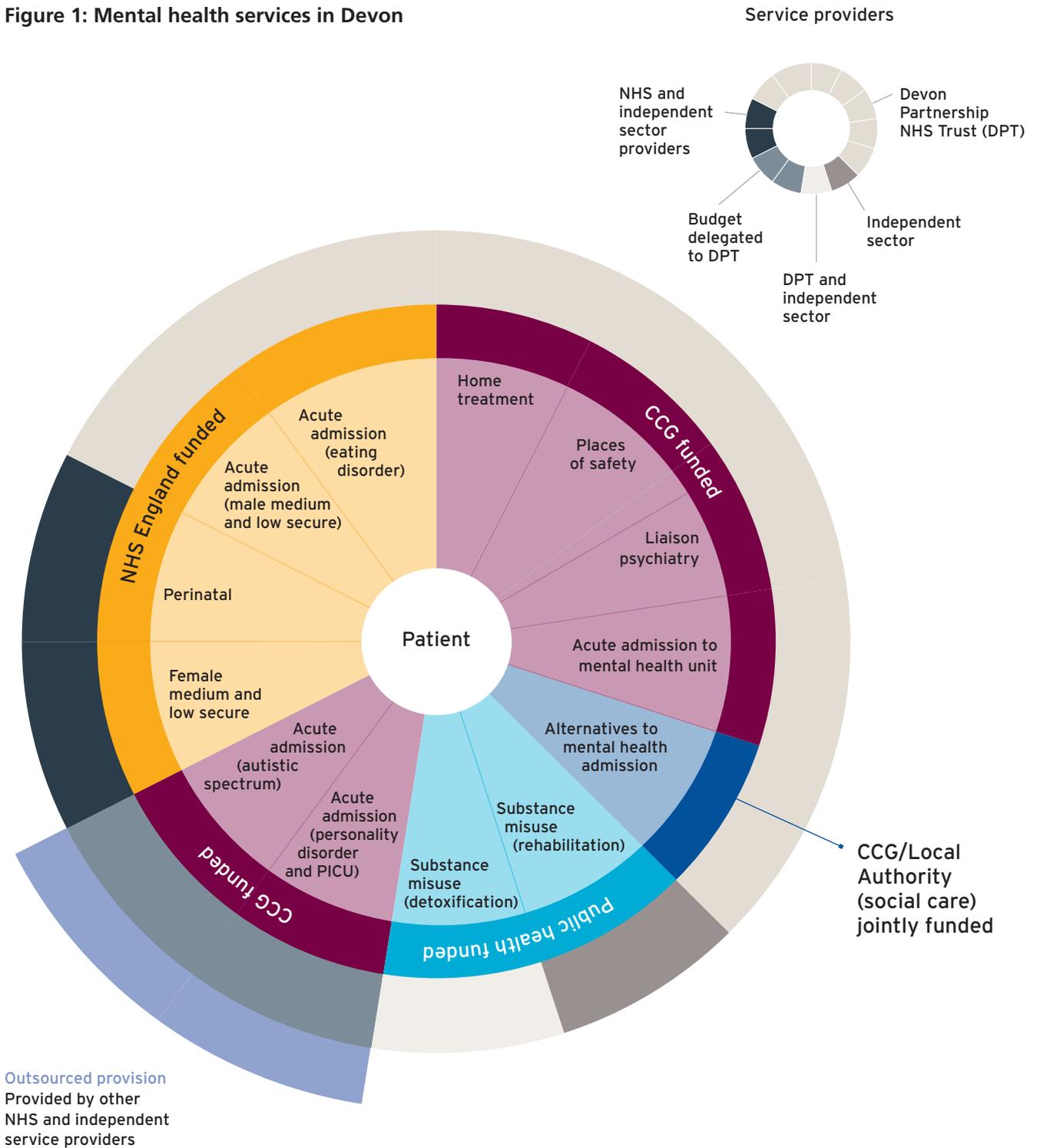
Figure 1 describes a very fragmented system and reveals how difficult it is for providers to offer a seamless and easily accessible system to patients and their carers. This is typical of many areas which have similarly poorly functioning mental health systems where:

- Services are often fragmented, provided by different providers with inadequate links between them.

- There are consequently many barriers to overcome in moving patients from one service to another and from one part of a service to another.

- Different organisations commission different parts of the system in ways that are frequently not coherent and consistent and which generate perverse incentives as will be discussed in Chapter 8.

- Information flows and communications are generally focused on the organisation and not centred on the patient – and don't flow easily across all these boundaries as discussed in Chapter 6.

The Devon example show some of the organisational boundaries that can provide barriers to smooth and efficient working. In addition to these boundaries between NHS mental health providers and Local Authority organisations there are also boundaries to cross to reach GPs and physical health providers. There is, for example, the very serious issue of mental health patients having poor access to services for their physical health needs. There is evidence that people with mental illnessess die younger[4,5] and have more difficulty in accessing physical care.[6]

Mental health Trusts have developed a variety of ways for working across these boundaries. They engage GPs through continuing professional development, introducing protocols and identifying GPs with a special interest in mental health, for example, in order to ensure and improve the quality of referrals. Similarly, there are mechanisms for ensuring streamlined working between Accident and Emergency departments, used by many mental health patients with Liaison Psychiatry schemes established in many areas. Some Trusts have also improved referral processes by creating a single point of access to particular services or to the whole system as in the example of North East London NHS Foundation Trust described in Box 2 in Chapter 2.

Figure 1: Mental health services in Devon

Service providers

- Devon Partnership NHS Trust (DPT)
- Independent sector
- DPT and independent sector
- Budget delegated to DPT
- NHS and independent sector providers

Outsourced provision
Provided by other NHS and independent service providers

Data source: Devon Partnership NHS Trust

Box 2: Types of community teams showing how many Trusts provide them and whether they have a single point of access[10]

Community team	Number of Trusts who provide (%)	Trusts which have a Single Point of Access to this service (%)
Generic CMHT	81	66
CRHT	76	53
Assertive Outreach	52	34
Early Intervention (incl Early Onset Psychosis)	69	40
Assessment & Brief Intervention	50	43
Rehabilitation and Recovery	36	28
Forensic	55	34
Eating Disorders	59	33
Mother and Baby	38	22
Older People	76	53
Memory Services	67	47

The provision of services by the voluntary and private sectors has the potential to bring with it new and additional skills and capacity but also adds further complexity. The Commission noted in particular that voluntary and private organisations often provide important specialist services but that they are rarely directly involved in planning at a local level and that contractual arrangements can often be different from those with public sector organisations. In addition, not all community mental health services are provided by the NHS, and there are good examples of third sector providers running crisis houses with the CRHT acting as gatekeepers such as The Richmond Fellowship's crisis services in Leicestershire and Derbyshire.[7]

There are also specific issues with regards to patients who are sectioned and those referred from the criminal justice system. The proportion of patients admitted under the Mental Health Act 1983 has increased in recent years[8] and is another factor which reduces flexibility and speed of action thereby making the whole system harder to manage. The processes for discharge can be longer for patients detained under the Mental Health Act, whilst patients transferred from prison are sometimes admitted

to a particular ward and then cannot even be moved internally from that specific ward to another without additional process and authorisation from the Ministry of Justice.

There is also significant variation in levels and type of provision around the country. Box 2 provides an overview of data collected by NHS Benchmarking on the types of specialist community teams offered by mental health Trusts across England and whether they have a single point of access. It shows that there is no single type of specialised community team that is provided in all 58 Trusts. The low levels of rehabilitation and recovery teams are thought to be partly because these functions have been absorbed into other types of team with some re-labelled as Assertive Outreach Teams.[9]

These and other specialist services affect the acute adult service. In child and adolescent services, for example, there is evidence that improved availability of early intervention services could prevent up to 50% of adult mental illness.[11] Moreover, there are too many times when adolescent patients are treated on adult wards because of a lack of capacity in age-appropriate services.

The consequences of a poorly functioning system

The problems described here are very familiar to patients and carers as well as to people working within the service. The Commission heard many examples of poor liaison and communication and difficulties at all these boundaries. A survey conducted with Approved Mental Health Practitioner (AMHP) leads in Local Authorities in 2013 as shown in Box 3 brings these problems clearly into focus – showing how difficult it is to work across boundaries, how bed shortages aggravate the situation and how patients and their carers suffer.

The survey of mental health wards discussed in the last chapter, summarised there in Box 1, showed that many people remained in hospitals because there was nowhere else for them to go or were admitted in the first place because of a lack of alternatives. More generally, the Commission heard from many people that patients were often cared for in the wrong part of the system – as inpatients when they could have been cared for in the community, for example, or by community teams when they could be cared for in primary care – and that this might affect around 20-30% of all patients. This means that they may be receiving inappropriate care and becoming more dependent than necessary, and that the system is being unnecessarily wasteful of resources.

These problems are associated both with difficulties in accessing services and in being discharged – "stepping down" or "stepping up" – and mean that significant proportions of people can be in the wrong bed or part of the system at any point in time.

There is limited nationally available evidence on this issue however some local studies have been commissioned or undertaken in parts of the country. Figure 2 draws together evidence received by the Commission from mental health Trusts relating to the proportion of people who have been effectively "stuck" in various types of bed-based services over the past five years.

Box 3: Difficulties faced by Approved Mental Health Practitioners in working across organisational boundaries[12]

A survey of AMHP leads across 152 local authorities in England conducted by the College of Social Work in 2013 examined how the availability of inpatient beds and police and ambulance services was affecting AMHPs' ability to undertake their role effectively:

- 63.8% of respondents reported that a Mental Health Act (MHA) assessment had been postponed at least twice in the last six months as a result of the lack of police availability to provide support at the assessment.

- Under Section 140 of the Mental Health Act 1983, CCGs are required to designate an inpatient unit where patients should be admitted in 'cases of special urgency'. 41.8% of responders reported that there was no such arrangement in their areas and 45.1% reported that they did not know if there was an arrangement in place.

- The availability of appropriate inpatient psychiatric beds was a concern both at the assessment and admission stages. Only 34.1% reported no delays to assessment in the last six months, a figure dropping to 19.8% for compulsory admissions. The longest delay was reported to be 21 days.

- 16.5% of respondents stated that in one or more cases a person had been detained under the MHA because an informal admission to psychiatric inpatient care was not available.

- Out of area treatments were a concern in some areas, with 31.9% of responders stating that a patient had been detained on at least one occasion after objecting to an informal admission to an out of area / distant hospital.

Figure 2: Summary of evidence from local studies reviewing the number of patients in bed-based services who no longer require the service

- Acute Ward
- Rehab Ward
- Out of area treatment – Rehab
- Supported accommodation
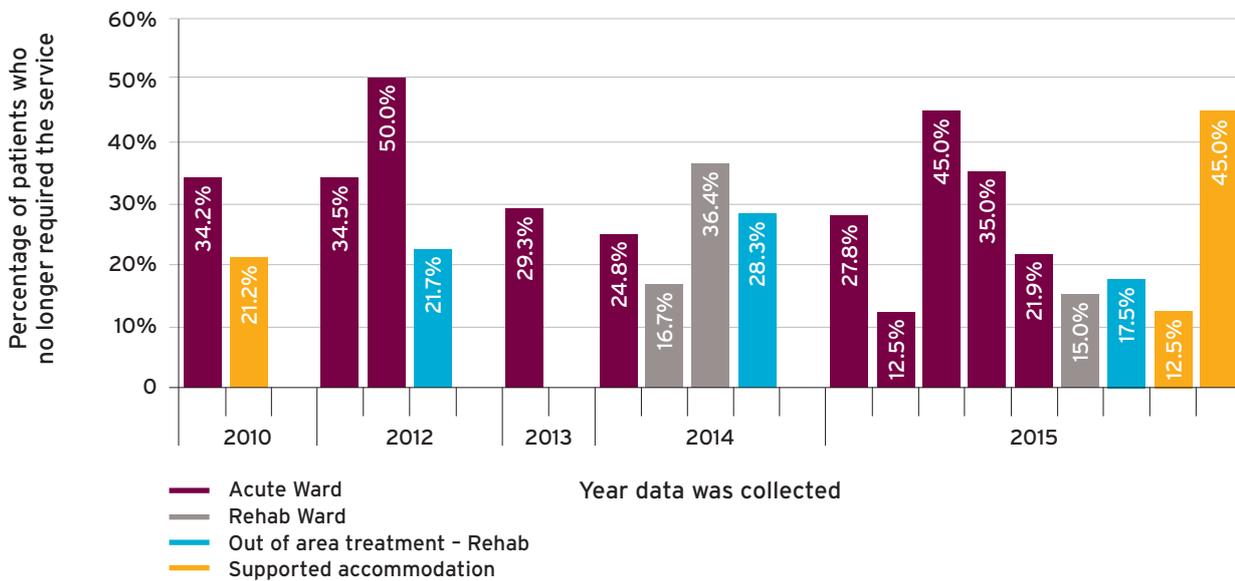
There is even less systematic evidence of the scale of this problem in non-bed based services. A researcher discussed this issue on behalf of the Commission with service managers in a number of Trusts. His preliminary findings show that in the view of service managers perhaps 10 to 15% of patients were being looked after unnecessarily in Access services, CMHTs and CRHTs.

These analyses are very limited in scope but, together with the anecdotal evidence, they strongly suggest there is a need for commissioners and providers to carry out this sort of analysis in every part of the country – both to ensure that patients are getting the care they need and to reduce what appears to be a very substantial amount of waste. Some providers have already made good progress in addressing these issues. The example of North East London NHS Foundation Trust described in Box 2 in Chapter 2 shows how one Trust systematically analysed the patients using its services and made improvements as a result.

Making the system coherent

Service providers and commissioners have, as has already been noted, found various ways to work round these difficulties but much more needs to be done. Health and Wellbeing Boards, commissioners and Local Authorities with devolved responsibility for health have particular responsibilities here. However, there is also scope for far more sharing of operational information, joint planning, and shared approaches to services and innovation.

There are important balances to be struck here between local autonomy and innovation and national guidance and requirements. The National Service Framework for Mental Health (NSF), introduced in 1999 set out a clear guide on many interventions and on the structures and types of community teams needed in each area.[13] It reviewed the evidence for all its proposals and published its assessment of the strength of evidence in each case. The NSF led to major investment in community based services and the growth of community based teams throughout England.

Since 1999 a combination of greater local devolution of authority, new experience and evidence and, in many cases, shortages of funding have led to changes in these structures and resulted in the very mixed national picture of community teams presented in Box 2. The Commission was told that in some cases community-based teams had become generic catch-all services which were unable to deal effectively with many of their patients with more specialised needs. In other cases, it was told that improvements had been made by re-grouping and realignment of services. There is now considerable research literature and debate about this with, for example, studies showing the negative impact of CRHTs moving away from "fidelity" to the specified model.[14,15]

While detailed discussion of these areas is outside its remit, the Commission notes the importance of research and evaluation and welcomes the development of NICE guidelines for most acute conditions.[16] It also notes the importance in a system of having as few "hand-offs" between different teams as possible and the fact that any change anywhere affects every other part of a system as described in Box 1. This discussion also reveals the importance not just of undertaking high quality research and evaluation but also of disseminating the results and acting on them. This is a theme that underlies many of the findings and recommendations of this report.

There are, however, some very good examples where a shared approach operates effectively across a whole system in a consistent fashion. Examples include the Care Programme Approach which provides a method for coordinating care for individuals across organisations and the use of Care Pathways designed around the needs of groups of people such as the example of the Acute Care Pathway with which this chapter opened.

Most recently, the Crisis Care Concordat was developed and implemented in 2014 in order to manage care across the boundaries between health and social care and the criminal justice system. Early analysis suggests this has had positive effects and that lessons can be learned for the development of other similar cross-organisational and cross-boundary initiatives. The number of times patients were detained in police cells under Section 136 (s136) of the Mental Health Act in 2013/14 in England was 6,028, a reduction of 24% from the previous year. The use of police stations also reduced as a proportion of all s136 detentions, from 36% in 2012/13 to 26% in 2013/14.[17]

Health and Wellbeing Boards and Local Authorities

Health and Wellbeing Boards have a responsibility for the oversight of services in their area and for enabling partnership working between organisations. While Health and Wellbeing Boards don't have direct executive power over services, their statutory role does include a requirement to promote the integration of health and social care. There has been little guidance on how this should happen in practice with the result that many different approaches have developed both in terms of membership and focus.

Health and Wellbeing Boards are, however, relatively new and generally have not yet addressed mental health as a whole system. Moreover, mental health – as so often – does not receive the same priority as physical health on their agendas.[18] The devolution of powers in Manchester with joint management of health and Local Authority services[19] and the piloting of shared management for mental health services in Lewisham[20] provide the opportunity for bringing many services together in these areas within the same management structure. These are likely to be forerunners of wider changes. The Government has committed to integrating health and social care by 2020,[21] and experience from these early examples will inform these national developments.

These structural changes and organisational changes are welcome. However, the Commission noted on its visit to Northern Ireland that the fact that health and social care are part of the same structure does not eliminate problems at the boundary between them. Successful partnership working is about leadership and relationships and needs to be supported by appropriate systems and processes. This mixture of elements is revealed in Box 4 and is an example of how one very large Trust deals with these difficult systems issues.

Box 4: An example of working across boundaries within a Trust's area

Tees, Esk and Wear Valleys NHS Foundation Trust is one of the largest mental health organisations in England. It works with eight Upper Tier Local Authorities, eight Health and Wellbeing Boards, three Police Forces, five Acute Hospital Trusts, 11 main Clinical Commissioning Groups and 15 emerging GP Federations.

The Trust's services are operationally led and managed in four geographical based Directorates (as well as a fifth specialist Directorate) to facilitate local engagement with statutory and non-statutory agencies. Quality standards, protocols etc. are developed by five Specialty Development Groups on a Trust-wide basis:

- Three Health & Wellbeing Boards have a Mental Health Partnership Group reporting directly to the Board, which supports whole systems working, including patient and carer representation. One group has a housing sub-group.

- Three Mental Health Crisis Care Concordat groups which have excellent agency engagement.

- The Trust itself setting up a provider Contact Group independently chaired to ensure coordinated, cooperative working between all relevant health and social care providers in a locality, which is characterised by having a great deal of social capital providing unrivalled opportunities to benefit patients and carers.

- Information sharing protocols.

- Co-location of staff, for example Street Triage staff and police.

- Housing Officers, funded by the Trust, working in inpatient services to support patients secure appropriate housing working directly with housing providers and residential care home providers.

Working in partnership is one of the Trust's five strategic goals and is reflected throughout its values and behaviours. Effective partnership working is expected of staff at all levels in the Trust because, as the Trusts says, it is otherwise not possible to meet the needs of patients and carers.

The commissioning of services

Commissioning is currently one of the major causes of fragmentation in many areas but also has the potential to be a major force for improvement. It is split between three different bodies as shown in Box 5.

Box 5: Responsibilities for commissioning

1 **Clinical Commissioning Groups** (CCGs) are responsible for the commissioning of non-specialist adult secondary care mental health services. These may include the following types of services:

   A Acute adult inpatient services.

   B Community-based services such as Crisis Resolution/Home Treatment teams, Assertive Outreach Teams and Early Intervention in Psychosis teams.

2 **NHS England** commissions specialist mental health services for adults and children at national level. These specialised services are:

   A Low secure forensic mental health services.

   B Medium secure forensic mental health services.

   C Specialised mental health services for the deaf.

   D Gender identity services.

   E Perinatal mental health services.

   F Tier Four (inpatient) Child and Adolescent Mental Health Services.

   G CAMHS secure services.

   H Tier Four (inpatient) personality disorder services.[22]

   It also commissions primary care.

3 **Local Authorities** commission:

   A Social care services.

   B Mental health services, sometimes jointly with CCGs.

   C Drug and alcohol services.

   D Supported accommodation.

Commissioning is not a simple matter and there are many complications with, for example, primary care. There is currently no standardised model for the commissioning and provision of primary mental health care services. Existing service provision varies greatly and in most areas is likely to result from historical factors.[23] Currently, gaps at the interface between primary mental health care and secondary mental health services can mean that patients disengage, revolve or get 'stuck' in different parts of the system.[24]

There are further complications with social care where Local Authorities provide the personal help and support people receive in addition to healthcare or treatment due to illness, disability, old age or poverty. Unlike healthcare, social care is means tested. Local Authorities have a responsibility to ensure that social care is commissioned and provided for those who qualify as eligible in their area and that those who are not eligible for free care have the information they need to buy their own care.[25] Since 2009 half a million fewer people are eligible for social care. There has been no reduction in demand and increasing concern that this adds greater pressure to the whole system.[26,27]

Despite the importance and the difficulty of these tasks, the Commission heard that leadership of mental health commissioning has been variable and often poor at CCG level. The Commission was told by its Advisory Board that a worryingly high number of clinicians and commissioning support staff responsible for mental health within individual CCGs (or networks of CCGs) do not know enough about the subject, and that it is effectively 'any other business' at many meetings rather than a core topic of discussion.

The Commission was also told that many mental health commissioners do not stay in the role for very long, meaning that valuable experience is frequently lost as soon as it is gained. As the All Party Parliamentary Group on Mental Health reported in 2012, GPs may well not possess enough knowledge about mental illness to commission mental health services effectively,[28] and the Commission has been told that Commissioning Support Units are highly variable in their ability to support the commissioning processes. As an example, the Care Quality Commission raised the concern in their 2013/14

Monitoring the Mental Health Act report that many CCGs were not aware of their obligation under Section 140 of the Mental Health Act to notify their Local Authority about arrangements for urgently receiving patients in crisis, and called for CCGs to rectify this.[29]

One member of the Advisory Board suggested that the mental health commissioner role needs to be 'professionalised', with quality improvement methodology, data literacy and basic knowledge about mental illnesses highlighted as specific areas for improvement. Previous attempts by NHS England to provide support and training for GPs through development programmes have been an important first step in raising awareness and competency, but more will need to be done to embed this engagement.

Joint commissioning and lead commissioners

This chapter has already noted some of the difficulties caused by the split between commissioners. A key factor affecting whole system functioning is the ability of people to pass 'up' and 'down' the acute care pathway irrespective of the funding stream. During times of an acute crisis or high risk people can quickly move 'up' the mental health system – sometimes to an out of area facility – as it is the crisis and/or risk issues that drive this. However, once these factors have reduced there is rarely the same urgency to move people 'down' the system. This is compounded by the fact that different levels in the system are usually funded through separate financial streams with little incentive for those budget holders elsewhere in the system to facilitate people utilising their budget.

Inevitably, the greater the pressures on health and social care budgets are, the more difficult it will be for the respective CCG/Local Authority budget holders to work together and see the wider picture. Many have apparently reacted to such pressures by retrenching to defend their position. Moreover, when decisions are made by one commissioning organisation that have a directly or indirectly deleterious impact on the other then this can reinforce the view that they are not "in it together" and further damage the relationship, creating a vicious circle.

Box 6: The development of collaborative commissioning in Essex

NHS and Local Authority commissioners in Essex have been working together over the last two years to strengthen collaborative commissioning arrangements for mental health services in Essex. There are seven CCGs and three local authorities which commission mental health services in Essex but only two main specialist mental health providers. Collectively commissioners spend in excess of £200m on mental health services across the county.

The commissioners decided to act because of:

- A recognition of the increasing importance and value of mental health services in the lives of local people, and also in delivering wider organisational and system objectives.
- The clear need to place mental health within a wider integration agenda between health and social care and a key enabler to healthy communities and managing demand for other services.
- Dissatisfaction with some aspects of performance, quality and accountability from existing services – but a recognition that the commissioning arrangements were contributing to this issue through inconsistent, poorly coordinated approaches from different commissioners, and a lack of expertise in some areas. Ultimately the fragmentation in commissioning was clearly translating into fragmented frontline services.
- Frustration from providers of a lack of alignment and coordination between commissioners causing planning blight at a strategic level and increasing transactional overheads for all.
- The need for commissioners to work together to be clear about their medium-term collective intentions, beyond the usual broad strategies, to enable providers to address their own sustainability issues.
- The need to consider their commissioning capability. An external review for adult mental health services showed that there were between 30 and 50 individuals fully or partially involved in mental health commissioning across the county, but that still there was a lack of specialist service knowledge, technical commissioning expertise, and visible leadership on mental health amongst the commissioners.

The commissioners started by establishing a collaborative programme for Tier 2 and Tier 3 Child and Adolescent Mental Health Services (CAMHS) which led to the commissioning of a single new county-wide provider for emotional well-being and mental health services for children and young people. This involved a much stronger outcomes-based approach to commissioning, a pooled budget, a collaborative governance arrangement and a single commissioning team hosted by a lead CCG. The new service model is still bedding in but the feedback about the new service model and the increased capacity generated through economies of scale has been very positive. There was no increased investment from any commissioner to achieve this result.

Commissioners are now developing 1, 2 and 5 year plans for the more complex area of adult mental health services. They have gone back to basics and developed a really strong countywide mental health JSNA (Joint Strategic Needs Assessment) as a first step and there is strong leadership and an agreement to pool existing commissioning resource. Their work together on CAMHS has created a strong foundation from which to move forward. The work done to date has been sufficient to allow the providers to take action confidently about their own futures, and there is a commitment for the commissioners to have a single plan by the summer, and a procurement strategy by the autumn. Decisions about changing the profile of commissioning resources will follow on from the delivery of this plan.

The commissioners report that there have been many challenges – as well as much satisfaction and humour – along the way, but at the heart of delivering these changes is the need for strong and committed leadership, the need to develop trusting relationships at an individual and then organisational level, some technical expertise and clarity about process, and the need to understand and then respect individual commissioner priorities. As they say, *"collaborative commissioning cannot be a proxy for a 'one size fits all' approach and good mental health commissioning capability is increasingly rare and precious, and needs to be used to best effect."*

There are now a number of instances where a lead NHS CCG takes responsibility for working with mental health providers on behalf of other CCGs. In addition, many organisations are currently making use of joint funding and budgeting mechanisms to support joint commissioning across health and local authorities, however the nature and scope of these arrangements varies widely between localities (and even services) and best practice has not yet emerged.[30] Box 6 describes the way joint commissioning is developing in Essex – and some of the difficulties involved. It also reveals that commissioners there purchase between them almost £200 million of services – more than with most Trusts dealing with physical services – and therefore highlights the importance of addressing this neglected area.

There are also a few examples where a Trust has been given 'lead provider' responsibility by local commissioners and sub-contracts services from other bodies on behalf of the commissioners. An example of a very recent 'lead provider' initiative is shown in Box 7 below.

Box 7: Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) role as a 'Lead Provider'

TEWV now acts as a 'Lead Provider' for some services. This means that it has been given authority by one of its nine CCGs to effectively sub-commission services on their behalf from other providers.

This is different from conventional arrangements in that this is largely an outcome based contract which encourages TEWV to fund voluntary sector organisations to provide support services as well as be responsible for all out of area admissions. This latter point is not unusual but what is unusual is the responsibility for providing and/or commissioning a "whole system "except social services. In addition it is a five year contract with an agreed contract price.

For all the other eight CCGs TEWV serve one year block contracts are in place and it is the responsibility of the CCG to contract directly with other providers whether it be voluntary or private sector providers. It is not TEWV's role to fill the gaps.

The Commission also noted the Health Services Commissioning (Equality and Accountability) Number 2 (2015-2016) Private Member's Bill developed by Rehman Chishti MP (with support from the Royal College of Psychiatrists) with interest. If passed, this Bill would provide that all commissioners of health services exercise their functions with a view to securing the objective that health services meet the needs of people with mental illness and learning disabilities, and are to report how they have met this objective in their annual report to the Secretary of State for Health under Clause 14Z15 of the Health and Social Care Act 2012, including how they have:

- *improved the quality of mental health services (in terms of the clinical outcomes that have been achieved and patient experiences of said services).*
- *reduced inequalities in access to physical and mental health services for people with mental health problems and learning disabilities.*
- *reduced inequalities in physical and mental health outcomes for people with mental health problems and learning disabilities.*

People with learning disabilities

In looking to the future, service commissioners and providers need to be aware of the potential impact of the new strategy for people with learning disabilities *"Building the Right Support"*[31] which is likely to lead to more people with learning disabilities who may also have mental illnesses being treated in mainstream mental health services. Box 8 gives a brief excerpt from the policy statement which suggests the potential impact it might have on mental health services.

There would similarly be an impact from any changes in the criminal justice and prison system which led to more people being treated for their illnesses rather than imprisoned for their offences.

Box 8: Implications of the new strategy for people with learning disabilities[32]

Everyone should expect universal NHS services to employ clearly identified and readily accessible primary and secondary healthcare 'liaison' workers who have specialist knowledge and specific skills in working with people with a learning disability and/or autism which enable them to advise those services on how to make effective adjustments.

Everyone should expect mainstream mental health services to regularly audit how effective they are at meeting the needs of people with a learning disability and/or autism. The Green Light Toolkit should be used to both evaluate services and to agree local actions to deliver real improvements. In many instances this will require investment in mainstream mental health services such as Child and Adult Mental Health (CAMHS) Services, Improving Access to Psychological Therapies (IAPT) and services that are helping to deliver against the Crisis Care Concordat. In other instances there will be new initiatives to support mainstream mental health services to make reasonable adjustments to their pathways of care and support, and to improve access to those services.

People who present an immediate risk to those around them and/or to themselves may require admission to a hospital setting when their behaviour and/or mental state is such that assessment and/or treatment is temporarily required that cannot be provided safely and effectively in the community. They should have access to high quality assessment and treatment in non-secure hospital services with the clear goal of returning them to live in their home. Sometimes people will be detained under the Mental Health Act if the necessary conditions are met.

People with a learning disability and/or autism should be assessed and treated in mainstream inpatient services where this is the most appropriate option. This is likely to be the case for people with a mild learning disability and/or autism who have a mental health problem of a type and severity that warrants inpatient care. Providers should make the reasonable adjustments to enable this (e.g. liaison nurses and collaborative working with learning disability and/or autism specialists). This might require providers to designate particular wards as suitable for this purpose.

People whose learning disability and/or autism is more significant and who require an adapted environment and/or intensive specialist treatment and care should be admitted to a specialist unit if they require inpatient care. These specialist beds should be increasingly co-located within mainstream hospital settings as part of integrated specialist inpatient services, rather than in isolated stand-alone units. With the right support at the right time in the community, use of inpatient services should be rare and only for clearly defined purposes.

Housing

A shortage of housing was the single biggest issue raised in the Commission's survey of acute adult inpatient wards[33] described in Chapter 2 and was mentioned by many people in meetings and during the Commission's visits to services. The term "housing" covers a range of different facilities from supported housing of various sorts to group homes and independent living. The most immediate concern is the need for an adequate supply of appropriate housing available at short notice for patients being discharged from an inpatient unit. Staff on inpatient units must have access to such housing provision without the need for lengthy referral processes.

More generally, there are currently not enough specialised housing options available for people with mental health problems. At the end of August 2014, only 58% per cent of people aged 18-69 treated under the Care Programme Approach were recorded as being in settled accommodation.[34] Homeless people are also known to have higher rates of mental health problems than the general population.[35]

The Commission was told that one of the reasons why people with severe mental illness become homeless is that when they appeal a Work Capability Assessment they lose their benefits and their rent isn't paid. They are usually evicted, which adds to their mental health problems. This can obviously make the possibility of an admission more likely. Similarly, the Commission was told that many people who are not homeless at the point of being admitted also often fall behind with their rent or mortgage payments, and do not receive support during their admission to try and prevent this. Losing their accommodation can significantly delay discharge, as well as being a disruptive and stressful experience for the patient themselves. The Commission believes that this is an area that services should pay particular attention to at the point of admission or as soon as possible afterwards, potentially with dedicated staff working on it. Care Navigators (see Chapter 5) could play an important role in joining up health with housing in this fashion.

Secure and settled accommodation, with the right kind of support, can have a positive impact on the lives of homeless people with severe mental health problems by:[36]

- lowering the frequency of unplanned admissions onto psychiatric wards and the rates at which community mental health services are used.
- reducing the rates at which the people with severe mental health problems become homeless (thereby reducing the use of homelessness shelters).
- improving well-being among people with severe mental health problems.

Supported accommodation services should therefore be a key component in a whole-system care pathway for people with mental health problems, providing the basis for individuals to recover, receive support and in many cases return to work or education. However, despite the importance of good quality housing and appropriate support, people with mental health problems are twice as likely as those without to be unhappy with their housing, and mental ill health is frequently cited as a reason for tenancy breakdown.[37]

In England, around a third of working age adults with severe mental health problems (20,000 of around 60,000 people) reside in supported accommodation provided by health and social services, voluntary organisations, housing associations and other independent providers.[38] However, in mental health there has been a trend for health commissioners to see housing as outside the traditional care pathway and something both provided and commissioned by others. This clearly needs to change.

Government has recognised the importance of housing with the *Supporting People* programme (launched in 2003 to fund services to help vulnerable people live independently) and the Department of Health's *Care and Support Specialised Housing Fund* (CASSHF) programme, which is designed to improve the availability of specialised housing options for older people and people with disabilities, including those with mental health problems. Phase 1 of CASSHF funding led to the building of over 3,000 specialised affordable homes, although 90% of this funding went to projects supporting housing provision for older people.

These programmes have clearly been useful but, as the Commission's own survey shows, more needs to be done to improve housing provision and integrate housing more fully into the mental health system. The National Institute for Health and Care Excellence (NICE) is developing a guideline for the transition between inpatient mental health settings and community and care home settings to be published in August 2016 which should raise the profile of housing and will hopefully give new impetus to action. It will cover both:

- Admission to inpatient mental health settings from community or care home settings.
- Discharge from inpatient mental health settings to community or care home settings.[39]

In the meantime, commissioners and providers in each area need to build links with Local Authority housing departments where these don't already exist. Anecdotal evidence suggests that the appointment of staff with specific responsibilities for liaison with housing services produces beneficial results.

The Commission notes that delays with discharge sometimes arise not due to a lack of accommodation in and of itself but as a consequence of the patient's accommodation not being fit for habitation. Often simple repairs are all that are needed to resolve this but the systems to get these done are far too slow. The Commission heard of one example of a mental health Trust paying for Local Authority housing to be repaired as this was cheaper than the costs of accommodating the patient in their service while they waited for the Local Authority to act. This emphasises just how important joint working between these bodies is to the whole system functioning efficiently and in the best interests of the patient.

The development of adequate supported housing provision will need to include housing associations. There are emerging examples of new and innovative partnerships between commissioners, NHS providers and housing associations but there is more to be done to overcome the barriers to success and foster more partnership across the sectors. This will require co-operation between commissioners across the system to ensure that there is a strategic approach to commissioning that looks at need over the medium term.

Box 9 contains an example of a very successful partnership project for the provision of housing and care for people with severe mental health problems.

The innovative use of NHS estate is another opportunity yet to be fully developed. Much of the NHS land that has currently been identified for disposal will be released for housing development. More value could be created either by developing the supported accommodation necessary to provide for those with mental health problems, to support speedy discharge and step-down to recovery, or for other vulnerable groups with support needs or even to deliver a revenue stream that can be routed back into service delivery.[40]

Box 9: Tile House: Partnership between One Housing Group and Camden and Islington NHS Foundation Trust[41]

Tile House opened in September 2012 and provides 15 high quality, self-contained supported housing units in the Kings Cross area of London. Each resident has their own flat with purpose designed safety features to effectively manage risk, and communal areas which can be used for workshops and group sessions.

Tile House works with people with high levels of risk and complex needs who have previously been excluded from supported housing, including those with forensic backgrounds and those who are subject to Section 37/41 of the Mental Health Act.

Support is delivered by One Housing Group (OHG) in partnership with Camden and Islington NHS Foundation Trust (C&I) which provides dedicated, on-site clinical input. The service provides double staff cover 24 hours a day, seven days a week, with both One Housing and C&I staff on-site to provide a seamless, wraparound service for customers. Recruitment is carried out jointly between the OHG team manager and the C&I service manager. Shared team meetings also take place to ensure a consistent team approach. The service is funded through adult social care contract income, with OHG subcontracting the clinical inputs from C&I.

A two year evaluation of the project showed that there had been eight admissions to hospital among the customer group at Tile House, compared with ten admissions among the same group in the two years prior to Tile House opening. While a relatively small reduction, the service has been successful in enabling those customers who have been admitted to hospital to return to the service on discharge.

In the two years prior to the service opening, nine of the customers involved in this study spent an average of 317 days as inpatients, with a total of 2,856 occupied bed days. In the two years since Tile House opened, this had fallen significantly to an average of 81 days in hospital for each admission, with 404 occupied bed days for the five customers who had admissions.

The avoidance of admission is also key. There were 23 occasions when a customer might usually have been admitted to hospital, but the partnership approach between One Housing and the clinical team from the C&I NHS Trust meant that on-site support and input was appropriately utilised to manage and avoid crisis and mitigate the need for more expensive hospital admission.

The overall cost to the NHS in the year prior to people moving to Tile House was £527k compared to £71k in the two years at Tile House. Tile House has saved the system £443,964 per annum compared with previous placement costs.

Recommendations

This chapter has described the general fragmented nature of the mental health system and the difficulties this presents for patients, carers and staff. It 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 nationally and through innovation and development locally. The following two recommendations are designed to help improve the situation – through improving the functioning of the system itself and providing vital housing resources.

The commission recommends that:

4 **Service providers, commissioners and Health and Wellbeing Boards work together to improve the way the mental health system works locally – sharing information, simplifying structures where appropriate, and finding innovative ways to share resources and deliver services.**

This will involve:

- Joining up processes and systems wherever possible. This will build on existing shared mechanisms such as care plans and care pathways but should also involve better real time sharing of information and the engagement of all relevant bodies, including the private sector, in planning and communications.

- Mapping the whole system and analysing patient flows so as to identify how well the current system is being used and whether patients are being cared for in the right services.

- Simplifying the system wherever possible. This will involve reducing boundaries and hand-offs between organisations and services perhaps through using lead commissioners, lead providers and bringing together different types of services.

- NHS England working with commissioners to improve the whole way the commissioning process works.

5 **There is better access to a mix of types of housing – and greater flexibility in its use – to provide for short-term use in crises, reduce delayed discharges from inpatient services and offer long-term accommodation.**

This will involve:

- Commissioners, Local Authorities and housing providers working together to ensure that there is an adequate supply of appropriate housing to enable patients to be discharged from hospital when they no longer need inpatient treatment.

- This will require the Local Authority and CCG(s) to establish a decision-making processes that can occur within 24 hours of a referral being made and also to provide sufficient:

  – Crisis housing

  – Short-term temporary accommodation for patients ready for discharge

  – Supported accommodation for patients with mental health problems

  – Accommodation for patients with complex problems who may be difficult to house.

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04

Improvement, quality and safety

Summary

The last two chapters focused on capacity and improving access to acute psychiatric care. This chapter looks specifically at the quality of care on acute psychiatric wards and ensuring that care is both safe and therapeutic.

It starts with the vision of what a good acute service consists of, goes on to discuss quality on acute psychiatric wards and finishes by discussing the importance of embedding systematic quality improvement methodologies into mental health services.

It recommends the creation of a single unified and user-friendly set of standards for acute psychiatric wards and nurturing and accelerating the use of quality improvement methodologies in the mental health sector.

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 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.

Acute Psychiatric Wards: A spectrum of performance from "trapped" to "liberated"

Whilst the vision may be clear, the reality is that there is a spectrum of quality and performance around the country – ranging from inpatient units which are trapped in a constant process of crisis management to those where staff work purposefully to deliver high quality treatment and care. The Commission saw and heard of units and wards that are at different ends of this spectrum, with most falling somewhere between the two.

At one end are wards where crisis management affects everyone – patients, carers, ward staff and admitting doctors. Here patients told us they were stuck in locked wards with nothing to do – in some cases even pool tables had been banned for safety reasons. They were cut off from normal life. Ward staff often complained of being under pressure with no scope to do anything with the patients other than carry out routine observations and, in the opinion of patients, often ended up "hiding" in the office. Many doctors felt pressurised, with little discretion, chasing beds and practicing defensive medicine. This was the picture which so many people – professionals as well as patients – told us was simply unacceptable. It is not part of any therapeutic pathway.

The Commission also saw wards and heard about units which people felt were purposeful. Patients talked to the Commission about how they were engaged in activities and ways of thinking about recovery and focusing on the future. Several had peer supporters of different kinds helping them adapt. Ward staff spoke about the merits of having different professions available and working together, particularly the involvement of psychologists as well as nurses. Doctors took a positive view of their role – and what only they could contribute (such as clinical work, leadership and modelling good practice) – and about reaching out to the community.

This spectrum ranges from situations where people can only react to events, trapped in a constant process of crisis management, to ones where everyone is enabled to be proactive, liberated to take the initiative and help shape the future.

There appears to be no correlation between need or available resources and whereabouts a provider is on this spectrum. Some of the highest performing and most positive providers, for example, had low levels of beds and other resources and were in areas of great need. Moreover, some providers had managed to move themselves from the "trapped" to the "liberated" end of the spectrum, transforming their services as they did so.

Box 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 which is underpinned by humanity, dignity and respect.

- Staff working in acute care services who see understanding their patients as a key purpose of their work. The role of acute care staff is to sit alongside the patient, being both empathic and enabling change 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 misuse
  – 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 welcoming and calming environments. There should be zero tolerance for violence on the ward, with staff trained to recognise when patients are becoming disturbed and to act to alleviate the reasons behind this. All episodes of both verbal and non-verbal aggression should be reviewed on a daily basis by staff, and measures put in place to prevent a recurrence.

Quality – and the provision of safe and therapeutic care

The Commission was asked to consider how to ensure the provision of safe and therapeutic care for acute inpatients and, more generally, how to promote quality. The Commission recognises that the word quality can be used in many different and sometimes quite narrow ways by, for example, referring only to clinical practice or to patient experience. Here it uses quality to refer to the six dimensions identified by the Institute of Medicine in 2001:[1]

- Safety – Avoiding harm to patients from care.
- Effectiveness – Aligning care with the best of clinical science.
- Patient-centeredness – Customising care to the needs, resources, values, and background of each individual patient and carer.
- Timeliness – Avoiding non-instrumental delays for patients and clinicians.
- Efficiency – Reducing waste in all of its forms.
- Equity – Closing racial, ethnic, and other gaps in health status and care.

Good quality in all these aspects doesn't just arise by itself but needs to be planned for and worked at. Health workers will not automatically treat their patients well and services won't become equitable, efficient or safe without systematic attention to detail. Dr Joseph Juran 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. A great deal of attention in mental health has been given to quality control and the setting of standards which can be used to judge services and institutions. This approach provides guidance and direction for health workers as well as patients. It also provides a framework for accountability for performance and for identifying poor quality and making changes. However, quality control by itself can simply be seen as setting a minimum standard. It doesn't, however, lead to continuous improvement – always striving to do better – nor is it useful when circumstances or evidence change and new learning needs to be incorporated into practice. This is where quality planning and improvement are necessary.

Quality control, inspection and accreditation

Many organisations over the years have produced standards for all or parts of mental health services. The Care Quality Commission (CQC) as part of its wider oversight of mental health services operates an inspection regime for inpatient wards, assessing care against five criteria (see Box 2). The Royal College of Psychiatrists also produces very extensive documentation on standards and and runs the AIMS (Accreditation for Inpatient Mental Health Services) quality accreditation scheme for acute psychiatric wards.

By the end of May 2015 the CQC had inspected 18 mental health Trusts under their new regime (introduced in September 2014) and had rated eight. Of these eight, four were rated good, three required improvement and one was rated inadequate. They also inspected 14 independent mental health services, of which they rated seven. The first 'outstanding' rating was given to an independent sector provider.[3]

It is clearly important that inpatient wards meet the standards set by regulators and are aware of accreditation standards. It is also important for local clinical leaders to set and meet their own high standards for quality on their own units. Accreditation and regulation can describe what is available but are less good at determining how services are delivered in terms of the quality and kindness of staff-patient interaction, and the competency of individual staff members. Ultimately, the primary focus of a ward should be the patient and their family, not the regulator or accrediting service.

Box 2: The Care Quality Commission's inspection regime

Under the CQC's new inspection regime services are assessed to see if they are safe, effective, caring, responsive and well led. The CQC set out the performance of mental health Trusts in 2014/15 in its State of Care in England report.[4] It identified its key findings as follows:

Safe: The CQC's biggest overall concern was the safety of care environments, and in particular the safety on wards. They found that many services are still delivering care in old buildings that do not meet the criteria for modern health care facilities. In particular, there are concerns around ensuring facilities are adequately gender segregated and ensuring that all ligature points are removed. They also expressed concerns that the declining number of nurses working in inpatient settings may be influencing the safety of care provided.

Effective: One way the CQC assess the effectiveness of organisations is to check that staff have the right skills and training to deliver care effectively. Their findings for 2014/15 indicate that most staff in mental health organisations are appropriately trained and have access to training to develop their skills. However, only 42% of staff report having well structured appraisals.

Caring: CQC inspections found that the majority of people using services speak positively about the caring nature of the individual staff members that they come into contact with. However, their report, "Right Here, Right Now", published in June 2015, highlighted pervasive negative staff attitudes for patients receiving crisis care across a variety of settings.

Responsive: The CQC state that they are continuing to find problems with access to beds and describe one Trust where between November 2014 and January 2015 there were a total of 57 occasions where patients did not have a bed to sleep in and slept on sofas or in the 'quiet room' on a temporary bed. There were also 85 occasions across the acute wards in the same Trust where patients slept on a ward other than the one they were admitted onto, with some patients transferred during the night without notice. The CQC have now made ensuring access to local beds one of their "challenges" to the sector for 2015/16.

Well-Led: Although noting some excellent examples of local leadership, the CQC found that some Trust Boards were unaware of whether their decisions were having any impact on frontline services. They also found examples where data provided to boards was incomplete or inaccurate.

The Commission is very 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[5] – and the current work the College is doing with the British Standards Institute to update and streamline these – 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.

The Commission recommends that this statement and the Minimum Data Set for Mental Health should be aligned so that that performance against the standards can be monitored and reported on through the existing arrangements. This recommendation should be addressed alongside Recommendation 10 in Chapter 6, which calls for improved data on acute psychiatric wards. It also considers that this statement should be promoted amongst staff, patients and carers providing opportunities for it to be understood and, where appropriate, tailored to local services.

Quality improvement

There are, as noted above, many examples of standard setting and inspection, as well as of research about and evaluation of mental health services. All make invaluable contributions to quality. Many providers are also engaged in improvement programmes of some sort. Some are using explicit methodologies like 'LEAN' or the 'Toyota Way' and have had outside support in doing so, others have not. Some have had new investment, others have managed within their existing resources.

Whilst a lot is happening, there appears to be a need to spread greater awareness amongst clinicians, managers and commissioners that quality improvement in this context refers to a set of specific techniques and methodologies – with evidence of their efficacy – and not simply to a common sense and general concept of making improvements. Several studies suggest that a lack of knowledge and skills among clinicians and managers is a significant barrier to improving quality in health care.[6] Furthermore, there is neither a critical mass of staff nor provider organisations able to understand and use formal quality improvement methods and tools.[7] For example, while most clinicians will know about clinical audit and peer review, many are still unfamiliar with organisational or industrial quality improvement approaches such as 'LEAN' or 'Plan, Do, Study and Act' ('PDSA') cycles.[8]

The Royal College of Psychiatrists' 'core training' curriculum, for example, does not have a specific section on quality improvement although it does have a section on audit.[9] The 'higher training' curriculum for General Adult Psychiatry also includes a section on audit and links it more specifically to improvement. Trainees must *"show willingness to apply continuous improvement and audit principles to own work and practice"*. The section on leadership stipulates that trainees must *"demonstrate [the] ability to design and implement programmes for change, including service innovation"* although this is linked more to change management; these trainees are required to *"demonstrate an understanding of the principles of change management"*.[10]

Modules for some other psychiatric specialities include other references to quality improvement. For example, the Child and Adolescent Psychiatry higher training curriculum includes finding potential areas for quality improvement in their curriculum, and lists *"working with senior colleagues to formulate, implement and evaluate plans to improve quality of existing services"* as part of their clinical leadership section.[11]

Alongside this need for the development of greater awareness and skills there is a related need to share good practice and learning both locally and nationally. There have not as yet been many large scale efforts where Trusts have learned together as they made improvements through a "Breakthrough Collaborative" or other shared approach. The *NHS Five Year Forward View* makes the point that the *'fragmented and unfocused'* state of the NHS improvement infrastructure in England is a major impediment to the type, extent and pace of change now needed.[12] The two illustrations of improvement programmes in Box 3 and 4 below are good examples of how Trusts have set up learning processes within their own organisations, although this learning is not yet happening across organisational boundaries.

Box 3 gives an example of a quality improvement project which used a specific methodology and which changed the way the whole Trust worked with improvements in both quality and costs.

Box 3: The Purposeful Inpatient Admissions model

From 2009 Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) introduced a new way of working in order to remove waste and maximise quality. They utilised a 'Rapid Process Improvement Workshop' (RPIW) method of facilitating change learned from Seattle's Virginia Mason Medical Centre. This is an improvement process that brings together a Multi-Disciplinary Team (MDT) to examine how a process flows, eliminate wastes, propose solutions, and implement changes.

Occupancy was running at up to 106% in the two adult wards initially chosen with an average length of stay respectively of 29 and 47 days. Issues identified on the 'value stream map' included:

- Lack of a clear patient pathway.
- Eight consultants covering two wards.
- Eight to ten ward rounds per week.
- Lack of consistency in MDT involvement on the wards.
- Unacceptable levels of patients being sent out of area.
- High sickness absence.
- High number of ward-based incidents.

The work was led by a full MDT including consultants, psychologists, nurses and administration staff. The underlying concept was that "staff know best", and it is the task of management to give them the tools, methods and time to make improvements. While the staff participating in the RPIW are making the improvements, daily feedback sessions are arranged with the staff not involved in the project to ensure they are informed of any changes and have the opportunity to contribute ideas and feedback.

The team were presented with a number of tools (based on 'LEAN' methodology) to support the workshop, and ideas were generated by front-line staff to improve the process. This created a number of challenges for the team as they had to challenge themselves to adopt a new perspective on what was best for the patient and look at whether activities actually added value.

The main output of the project – the Purposeful Inpatient Admissions (PIPA) model – set out a completely new way of working for the wards. The improvements made included:

- Elimination of the weekly ward round and the introduction of an MDT daily report. The aim of this was to remove all "batching" from the decision-making process by making decisions daily. It also released more nursing time for direct work with patients.
- Visual control boards were introduced to the ward – mapping the patient journey through the service and ensuring the aims of admission were met within the specified timescales.
- The introduction of a MDT formulation meeting held 72 hours after admission to assess the patients' current state and agree the purpose of admission.
- A full '5S' of the office and its patient literature, ensuring that only necessary materials were on the ward and that patient literature was both up to date and relevant.
- The ward layout was changed to support a more productive flow.
- Standard work processes were developed for every step of the patient journey and for each staff member involved in the process.

Box 3: The Purposeful Inpatient Admissions model (continued)

The impact of the RPIW was felt throughout the Trust, and the new way of working revolutionised the way in which staff worked. In the 12 months following the RPIW the results showed that there had been:

- 21% reduction in bed numbers.
- 22% reduction in bed occupancy.
- 57% reduction in length of stay.
- 63% reduction in sickness absence.
- 79% reduction in violent incidents involving staff.
- 72% reduction in reports of violence & aggression.
- 100% reduction in patient complaints.

The PIPA model has now been shared across other Adult and Older Peoples inpatient wards across TEWV, with an estimated £20 million in efficiency savings. Further RPIWs have been held to refine the model and ensure continuous improvement.

Making improvements

There is a growing understanding of the factors that contribute to a successful Trust-wide improvement programme. The Commission identified a number of such factors – including leadership, a clear focus on the improvements to be made, open information and communication, organisational culture and a shared approach to quality and improvement – all of which are discussed here or in later chapters. Underlying all these features was a holistic and learning approach to improvement – the providers concerned changed their service models and clinical practice at the same time as changing organisational and management processes and systems and addressing quality and culture. Moreover, they did so quickly, learning as they went and changing direction as necessary.

Successful improvement methods engage and empower the people who are actually delivering the care as well as patients and carers in shaping the changes, because they are best placed to know what needs to be improved, how to improve it and where the waste and inefficiencies are. Using these approaches has the incidental advantage of also improving job satisfaction.

A study of quality improvement initiatives in general hospitals makes the interesting observation that internally motivated initiatives – which is what quality improvement projects typically are – are likely to have better outcomes than those where change has been externally led. It found *"that hospitals with a positive emotional and cultural context, as evidenced by strong emotional commitment to patients, a unified culture focused on patient care and active and engaged clinical leadership, appear especially conducive for fostering and encouraging internally motivated initiatives. In contrast, for hospitals with a negative emotional culture and political context, externally facilitated initiatives might be effective in providing*

the motivation and sometimes resources needed for implementation, however this may still not be enough to produce the changes needed to significantly improve outcomes, especially if the practices to be implemented involve behavioural changes and the facility lacks actively engaged clinical leadership and/or dedicated resources to encourage, monitor and ensure compliance". [13]

Medical Royal Colleges have a role to play in helping the delivery of quality improvement in organisations in which their members play important roles. The Royal College of Psychiatrists' Centre for Quality Improvement has a well-established record of facilitating change through peer-led accreditation and national audit.[14] The Royal College of Physicians has a well-developed care quality improvement department involving professionally led accreditation services and nationally led audit programmes.[15] The Royal College of General Practitioners meanwhile has produced a quality improvement guide for GPs and the whole practice team.[16]

The wider environment also has a role to play as identified in the Health Foundation's recent publication *Building the Foundations for Improvement* which demonstrated how five UK Trusts built quality improvement capability at scale within their organisations.[17] Key lessons from this document were:

1   Getting early board-level support is essential for any provider organisation considering building improvement capability at scale.

2   Provider organisations need to think carefully about how they will fund improvement capability programmes.

3   Provider organisations need to find ways of freeing up staff time to take part in training programmes.

4   Commissioners need to do more to support organisations developing improvement capability building programmes.

5   Arm's length bodies need to give organisations the time and space to develop and embed their quality improvement programmes.

One of these five Trusts was East London Foundation Trust which has a well-developed approach to quality improvement as demonstrated by the example in Box 4.

Critical success factors for a good quality acute care pathway

The Commission has brought together learning from previous studies with some new research of its own in order to identify the critical success factors for acute care pathways. As part of this programme site visits have taken place in two Trusts and information has also been collated from seven whole system reviews undertaken in the past five years in Trusts across the country. This data has drawn out critical success factors as described by clinicians, managers, commissioners and patients and carers. The list is not exhaustive and is in no particular order but could form the basis of system redesign guidance and subsequently future benchmarking across the country. The Commission is keen to stress that these reflect personal opinions rather than a formal evidence base, and strongly suggests that any redesign efforts undertaken on the basis of these factors be carefully evaluated.

Box 4: Quality Improvement at East London Foundation Trust[18]

East London Foundation Trust began its Quality Improvement (QI) programme in February 2014, working with the Institute for Healthcare Improvement (IHI) to build its QI capability and to embed continuous improvement systematically across the organisation. The programme aims to reduce patient harm, improve patient experience and enable the Trust to provide the "highest quality mental and community care in England by 2020".

The central ethos of the programme is "bottom-up" staff-led quality improvement, with teams supported by QI coaches to run QI projects in areas where they would like to see improvement. Teams pick projects that matter to them and their patients, but are asked to think about how it might align with the Trust and directorate's priorities. Ensuring the success of these projects has involved the development of a deep support structure and internal expertise in QI capability. Over the last three years, six people have been on a year-long IHI Improvement Advisor course and over the last two years 500 staff have taken part in a six month QI training programme, which combines online and face-to-face learning and applies this to a real-life project.

Quality Improvement has been integrated into the Trust's existing organisational structures and forms part of the Trust's assurance, recruitment and training processes. The Trust has also developed a central QI team to co-ordinate the programme and provide support to projects across the organisation. The team has worked to build support for the programme across the Trust through road shows, learning events, celebrating improvement stories and by building a network of QI champions.

The investment in the QI programme is already beginning to show results with some of the most impressive results seen in a set of projects to reduce physical violence across the organisation. Since starting the projects the Trust has seen a 23% reduction in physical violence across the organisation as a whole, including a 57% reduction in violence across adult wards in one sector and a 50% reduction across three older adult wards.

Other successful projects have included:

- Reducing the number of missed doses of medication across six older adult wards.
- Improving waiting times to first appointment across Community Mental Health Teams, CAMHS teams and psychology services.
- Improving physical health monitoring within Community Mental Health Teams.
- Improving clozapine results handling across one locality.

The projects have also had a significant impact on staff satisfaction, with the Trust's scores for staff satisfaction, staff motivation, staff engagement and staff feeling able to contribute to improvements in their workplace being the highest across all Trusts in all sectors in the 2014 NHS staff survey.

Box 5: Critical success factors for the acute care pathway

Strategic factors

- Good oversight structures – see Box 6 for an example.

- Joined finance systems (pooled budget across commissioners – which can be combinations of health and/or Local Authority commissioners – with a post that oversees the management and use of the budget on behalf of the contributors).

- Proactive market management of supply for extra capacity (accessibility and cost).

- Proactive preparation for hand back to primary care – with users, carers and GPs.

- All health and social care commissioners on the Trust footprint working together.

- Joined operational roles across crucial parts of the system (eg. Director of Social Care and Housing, Joint Director of Commissioning for Health and Social Care).

- Clear local whole system model with all services (including non-statutory) having clear roles and functions where all are aware of the interconnection and there are no gaps or duplication.

- Minimal transitions.

- A clear strategy for people with personality disorders or highly emotional reactions to crises.

Clinical and administration practice issues

- Accurate data on use of services for clinicians that can be used in team meetings (data helpful to clinical practice).

- Identifying potential delays as early as possible (at admission or soon after – or even as part of the admission process).

- Consistency of risk thresholds amongst decision-making clinicians.

- Discharging people when they are well enough to engage with community services (they may not be symptom-free but need to be well enough to engage).

- Access to speedy housing repairs that enable people to return home.

- Good administrative support – particularly where caseloads are high in the teams.

- Local ownership of the "whole system" (i.e. right people in the right borough) within Trusts and across multiple bed sites.
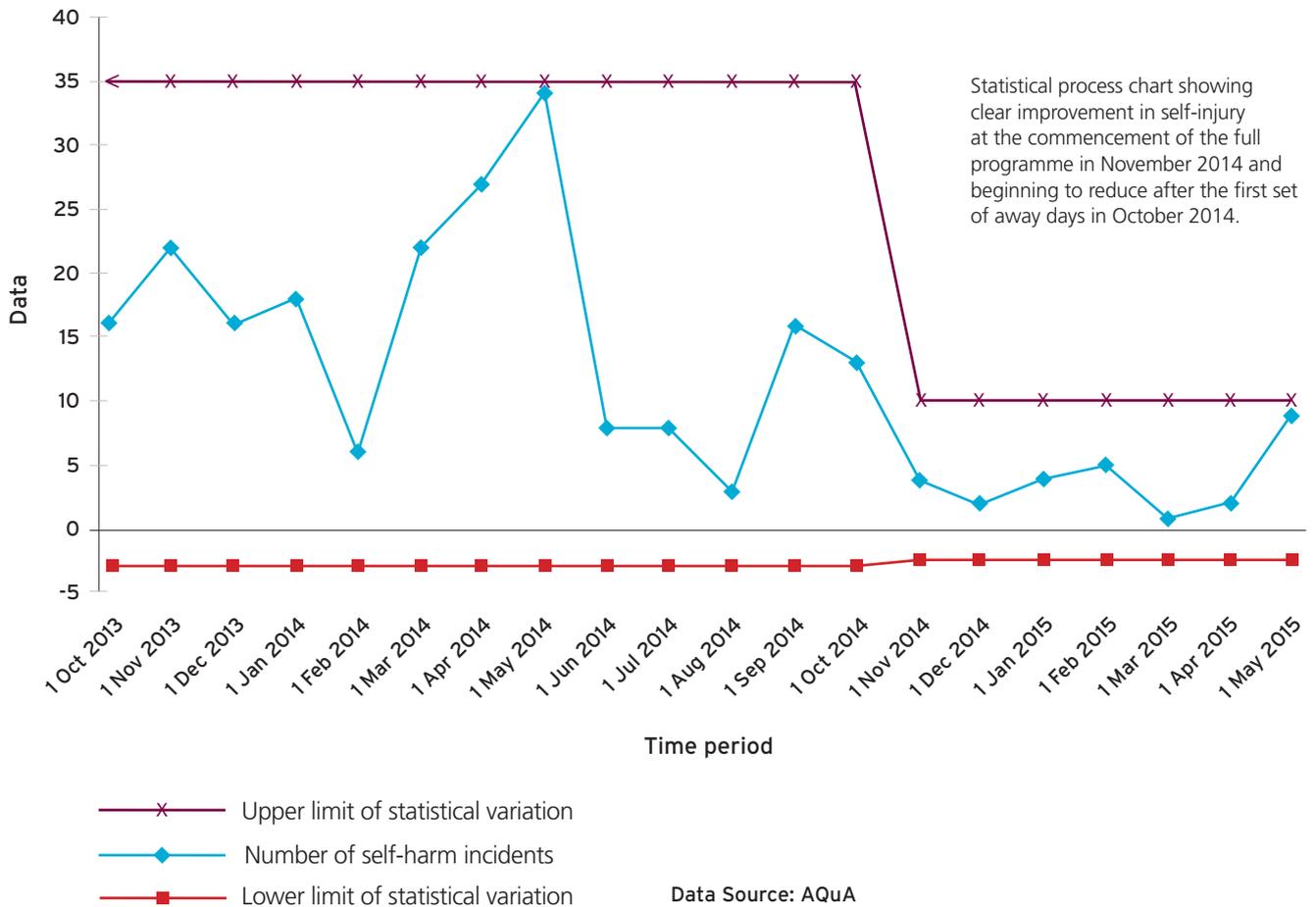
Workforce

- Recruitment and utilisation of staff across the system – having a stable workforce who can be moved to where they are needed.

Organisation of community services

- Diverting more people with less serious mental health problems to management in primary care.

- Establishing specialist personality disorder services.

- More active management of episode length and throughput within community services.

- Improving the use of time within community teams.

- Providing specialist support for people presenting repeatedly in crisis.

Figure 1: Statistical process chart showing self-injury incidence on Cavendish Ward

Statistical process chart showing clear improvement in self-injury at the commencement of the full programme in November 2014 and beginning to reduce after the first set of away days in October 2014.

Upper limit of statistical variation

Number of self-harm incidents

Lower limit of statistical variation

Data Source: AQuA

Quality improvement methodologies are also used by some Trusts to tackle identified problems on individual wards. Figure 1 shows a run chart of incidents of self-injury on Cavendish ward. Cavendish ward is based at Leigh Infirmary and is part of the 5 Boroughs Partnership NHS Foundation Trust. Cavendish is a female acute ward with 25 beds and has bed numbers above those that would be recommended nationally. It has a high volume of admission and discharges. The staff were feeling stressed from working with women who repeatedly self injure but

equally were unsure about what approach to take and there was inconsistent care at times offered to patients. A successful quality improvement programme was introduced based on co-production with an expert by experience, patients and staff across the disciplines and which used change methodology throughout supported by AQuA. The chart shows the impact of the changes with the number of incidents of self-harm reducing and fluctuating between narrower limits.

Box 6 – Oversight structure for 5 Boroughs Partnership NHS Foundation Trust

The CCG mental health commissioners for the 5 Boroughs Partnership NHS Foundation Trust from Halton, Knowlsey, St Helens, Warrington and Wigan have established a Trust Footprint Commissioner Group to oversee the implementation of whole system changes following a recent review of their adult and older adult care pathways, including the inpatient services. The group is led by the Director of Transformation at Halton CCG with the Executive Director of Operations of the Trust and mental health commissioning leads for each borough on the group.

The Group reports into five localities (their Local Authority boroughs) to their various health and Local Authority governance structures. These structures differ across the boroughs but provide the oversight for a large scale and complex change management process involving 10 commissioning organisations and the Trust.

Lines of reporting are clear and representation is accountable both within the group and to the respective oversight structures.

Upgrading services generally

The increased acuity of people in inpatient care mean that many services need to be upgraded to meet the new demands that this brings. At the same time complaints from patients about the quality of care and the lack of structure and activities need to be addressed as discussed in the next chapter.

Inpatient wards are having to manage a higher proportion of patients who are very acutely ill with many detained under the Mental Health Act. These high levels of acuity are, if anything, likely to increase in the future as providers develop more alternatives to admission and reduce delayed discharges – both of which are likely to have the effect of removing some of the less acutely ill people from the wards.

The Commission heard many complaints from patients and carers about the quality of inpatient care, as described in the next chapter. The Commission also noted evidence of demoralisation amongst staff, an under-valuing of the skills needed to work in these tough environments and difficulties in recruitment as described in Chapter 7.

The Commission saw 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, carers and the community. Patients, carers and staffing are discussed in later chapters, and this chapter will now briefly turn to the importance of the physical environment to safe and therapeutic care.

The physical environment

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.[19]

The Commission has heard that the quality of the physical environment of many inpatient services is inadequate and has seen examples first-hand. In contrast, Members of the Commission who visited the new build site of Hopewood Park, as described in Box 7, in Sunderland were extremely impressed by its novel design features including:

- Separate access to seclusion suites on the wards, so that newly admitted patients in crisis are not escorted to the suites in view of other patients.

- Multiple access points to an internal courtyard, which prevent bottlenecks where conflict between patients can arise.

- Large, unbarred low-set bay windows which patients can sit in, which make the environment seem less custodial.

Box 7: Hopewood Park

Northumberland, Tyne and Wear NHS Foundation Trust's new £50m Hopewood Park development in Sunderland opened in September 2014. The 122 bed hospital provides acute admission and treatment, psychiatric intensive care, stepped care and complex care rehabilitation services. A central facilities building accommodates a range of other clinical and support services.

The Trust considers that the hospital's design benefited greatly from its successful 11 year partnership with Medical Architecture, as part of the NHS Procure 21 framework. The hospital was the culmination of collaborative design development, including learning lessons from previous major capital schemes and numerous smaller projects and also applying international best practice and research findings to each design. Continuity of key personnel in the Procure 21 partnership was also a key factor.

The Trust has developed detailed design specifications for various types of rooms e.g. seclusion suites and en suite bedrooms involving clinical and other specialist staff such as patient safety officers and these were reviewed for Hopewood Park. Clinical staff also visited other Trusts' facilities with the design team, informed the design team in workshops about how their service operates 24 hours a day, tested some room mock-ups; and service managers took ownership in signing off design drawings for their services. Towards the end of construction, staff held a mock CQC visit and a "'live-in" which resulted in some design improvements. Various patient and carer engagement activities also informed the design development.

The Trust believes that whilst best practice processes in design development are important, good design is based upon a combination of "people factors" including good leadership, a knowledgeable design team which is enthusiastic and committed, encouraging innovative thinking; and developing strong partnership working.

Recommendations

The Commission concluded both that there was both a need for more explicit quality standards for acute psychiatric wards and a need to develop further the use of quality improvements methodologies across the whole of mental health. It therefore recommends that:

6 A single set of easy to understand and measurable quality standards for acute psychiatric wards is developed nationally with the involvement of patients and carers and widely promoted and communicated.

This will involve:

The Royal College of Psychiatrists together with NHS England, NHS Improvement, the Care Quality Commission and NHS Providers reviewing the current range of published quality standards in order to:

- Produce a short user-friendly statement of measurable best-practice standards agreed by all the relevant bodies.
- Promote this statement amongst staff, patients and carers providing opportunities for it be understood and, where appropriate, tailored to local services.
- Seek to align this statement with the Mental Health Minimum Data Set so that performance against the standards can be monitored and reported on through the existing arrangements. This recommendations should be addressed alongside Recommendation 10 in Chapter 6.

7 The growing awareness and use of quality improvement methodologies in mental health is nurtured and accelerated.

This will involve:

- Providers adopting a systematic approach to quality improvement and setting up training and development programmes for their staff.
- Providers and commissioners working with Strategic Clinical Networks to share good practice.
- Providers and commissioners nationally considering with NHS England what arrangements can be put in place to enable the active sharing and implementation of good practice nationally.
- The Royal College of Psychiatrists (RCPsych) and the Royal College of Nursing (RCN) actively supporting the development of quality improvement knowledge and skills amongst their Fellows, Members and Trainees and the RCPsych considering how its College Centre for Quality Improvement can play an even more active role in this.

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05

Patients and carers

Summary

This chapter looks at patient and carer experience in mental health. It describes patients wanting more activities on the wards and carers wanting to be more involved in assessments and planning care. It also examines the experiences of people from Black and Minority Ethnic communities who use acute mental health services.

The chapter contains recommendations for the greater engagement of patients and carers in their own care and in service design, provision, monitoring and governance. It also includes a recommendation for creating a creating a Patients and Carers Race Equality Standard for acute mental health care.

Patient and carer experience

The Commission met many patients and carers and heard from many more. It also established working groups to consider their issues and concerns in more detail. Two big themes, one negative and one positive, stand out. Firstly, whilst most patients and carers are grateful for the treatment and help they have received, the Commission heard a great deal of dissatisfaction with aspects of the quality of many services. Secondly, patients and carers need to be – and often want to be – more involved in decision-making and planning and their roles in the system could be greatly extended.

Most patients describe their experience of care as good. The 2009 CQC Inpatient Mental Health Survey found that over one in five (21%) of respondents rated their overall care during their stay in hospital as 'excellent', 28% said that it had been 'very good', 24% said 'good', 16% said 'fair', and 12% said 'poor'.[1] More recently, Friends and Family Test Scores for November 2015 show that 87% of patients would recommend the care they received from mental health services and only 5% would not recommend the care they received. For acute mental health services specifically, the score was slightly lower with 80% of patients reporting that they would recommend the service and 8% reporting that they would not.[2]

Some of the dissatisfaction and complaints the Commission heard were specific to individuals and needed to be dealt with through complaints and appeals procedures. Some, however, were more systemic:

- Many patients and carers complained about a lack of structure and activity (both therapeutic and non-therapeutic) on inpatient wards.

- Many carers complained about a lack of involvement and communication, particularly in initial assessment.

- Several patients from Black and Minority Ethnic communities complained of poor and inappropriate care and treatment – with some examples of overt racism – and the Commission heard about instances of homophobic prejudice from staff.

Although the Commission heard many examples of excellent care – including very poignant messages from former inpatients who said that the care they received had saved their lives – many complained about staff attitudes and behaviour. Some examples were truly appalling. One woman the Commission spoke to had been told by a nurse that she was 'the devil' and that she 'wouldn't be so selfish if she had a child'. The nurse had admonished her for having a lesbian partner and lectured her about God. Another was pressured by staff to go to church once they found out that he was gay, and he had religious leaflets put under his door. More generally, there were comments from staff as well as patients and carers about the importance of there being a welcoming and compassionate approach, with a clear message that this was sometimes lacking.

The Commission believes that many of these issues need to be dealt with through greater focus on quality and improvement as described in the last chapter and through staff management, training and attention to culture as will be discussed in Chapter 7. However, greater engagement of patients, carers and communities also has a part to play.

Activity on inpatient wards

The Commission heard from many patients about a lack of structure and activity on wards leading to frustration and boredom. In some cases this reflected staff resources rather than the provision of facilities; the Commission was told about one site where a gym was available but unused as no staff were available to supervise it. This is borne out by the 2009 CQC Inpatient Mental Health Survey, which noted a lack of activities available for inpatients. 35% said that there was too little to do on weekdays and over half (54%) reported that there were not enough activities available to them at weekends or evenings.[3] The Commission also heard of some instances where activity programmes were advertised, but in practice only happened sporadically, such as when the CQC made inspections. Aside from being obviously unpleasant, there is also some qualitative evidence to suggest that boredom not only delays recovery but can also lead to challenging behaviour.[4]

The Commission received a clear message that wards are too often places of containment rather than places where therapeutic benefit is maximised. In particular, patients and carers called for a wider range of therapies and treatments to be made available to inpatients including positive ward activities, psychological therapies, interventions targeting improvements in physical health (such as smoking cessation, guidance on alcohol and drug use, healthy eating and physical exercise), and the overall monitoring of patients' physical health and wellbeing. Wards that involved

community groups in purposeful activities on the wards were valued by patients as they were able to continue interventions even after being discharged.

This sort of development is part of what the Commission envisages as being a general upgrading of inpatient wards as described in Chapter 4. Star Wards, described in Box 1 is an example of good practice in this area.

Box 1: Star Wards

Star Wards is a voluntary membership scheme for inpatient wards and is run by a patient with experience of being treated under the Mental Health Act. It aims to improve the day-to-day experiences of patients on wards, with a particular focus on increasing the number of therapeutic and recreational activities available to patients, as well as improving the quality of patient conversations with staff. As of 2013, the scheme had around 651 member wards and 70 wards had achieved the "Full Monty" of meeting all of Star Wards' standards.[5]

Star Wards also maintains "Wardipedia", an extensive collection of best practice resources, including a variety of individual and group activities, from book clubs to tours of the local football club. A total of 50% of survey respondents reported that Star Wards had a "big or massive impact" on the activities in the ward and on patient satisfaction.[6]

Carer experience

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.

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.[7] 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 Rethink Mental Illness 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.[8]

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.[9,10]

The Carers Trust has developed the 'Triangle of Care' which 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 2. It is designed to help build a therapeutic relationship between all involved in mental health care, support recovery, sustain wellbeing and promote safety. There are currently 26 NHS Trusts in England which are members of this scheme.[11]

Box 2: The Triangle of Care[12]

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.

Some Trusts have developed programmes to support and engage carers through, for example, a nurse-led family and carers' service[13] or a Family Liaison Service.[14] Box 3 contains an example.

Box 3: An example of the triangle of care: Gresham Unit, Family Work and Support Service: South London and Maudsley NHS Foundation Trust (SLaM)

The Gresham Unit set up the Family Work and Support Service with the aim of improving access to psychological interventions for patients and carers from their wards, reduce readmissions, and work towards meeting the Triangle of Care principles.

Three different types of interventions were implemented across the acute wards over 18 months. These were:

• **A family 'awareness-raising' teaching session,** which was attended by 48 staff and led to an increase in the numbers of staff-family interactions. This training is now repeated annually.

• **A weekly carers' clinic,** which to date has been attended by over 124 carers. All carers involved in the clinic report being very satisfied/satisfied with the service.

• **Structured family work**, consisting of Behavioural Family Therapy, as recommended by NICE, is also offered to patients and their families. 76% of carers/patients involved in the work reported having made a lot of progress and 81% felt they would be able to continue to do so. Pre/post outcome measures also showed patient and carer distress reduced and well-being increased; family members felt less burdened; carers perceived their loved ones' illness as less threatening, meaning they had a greater understanding and felt more in control of symptoms. Prior to family work 62% of carers reported having someone to confide in. This increased to 92% following the therapy. Preliminary data shows patients are extending their time in the community following family work suggesting this intervention supports greater resilience.

The Family Work and Support service has won the NAPICU Poster Prize 2014 and a 2015 HSJ Patient Safety Award, as well as a Highly Commended Award at the National Positive Practice Mental Health Awards 2014 and 2015.

The experience of people from Black and Minority Ethnic group backgrounds[15]

The Commission heard particular dissatisfaction from people from Black and Minority Ethnic (BME) communities and one of its working groups looked at this area in some detail. There are also significant differences from the majority population and between different BME groups in how they access and experience acute psychiatric care. In particular the Commission noted differences in the following areas:

- **Crisis care:** evidence collected by Mind in 2012 suggested that different ethnic groups face different barriers to accessing crisis care. Indian, Bangladeshi and Chinese people had consistently low referral rates to Crisis Resolution and Home Treatment (CRHT) teams. BME groups, particularly Black Caribbean patients, were generally more likely to be admitted to hospital once they had been seen by a CRHT.[16]

- **Admissions:** in general people from BME groups are more likely than average to be admitted to psychiatric hospitals.[17] Both African-Caribbean and Black African patients are significantly more likely to be compulsorily admitted than White British patients.[18]

- **Detentions:**[19] A 2007 systematic review found that Black patients, BME patients and Asian patients were more likely to be detained under mental health legislation than White patients (3.83 times, 3.35 times and 2.06 times respectively).[20] A further study in 2014 showed that the probability of Black African women being detained was more than seven times higher than White British women, even up to a year into care. Black Caribbean and Black British women also showed nearly four times higher odds of being detained compared to White British females, and mixed Black/White women had nearly seven times increased odds.

- **Pathways into care:** some BME groups also experience different pathways into acute care, with a 1999 study finding that Asian and especially Black patients experienced more complex pathways and higher involvement with the police than White patients.[21]

- **Readmission:** a study of readmissions one year after involuntary hospitalisation showed that being of African and/or Caribbean origin was, among other things, associated with a higher involuntary readmission rate.[22]

- **Use of seclusion:** the 2010 Count Me In census of inpatient care found:

  – Higher than average rates of seclusion for the White/ Black Caribbean Mixed, White/Black African Mixed, Black Caribbean and Black African groups

  – Length of stay was longest for patients from the Black Caribbean and White/ Black Caribbean Mixed groups and shortest for Chinese and Bangladeshi groups.[23]

This is a complex picture in part because there are different groups involved but also because there are many different factors involved that influence use of mental health services. For example, there is evidence that some BME communities have higher incidence of mental illnesses[24] and of the increased incidence of mental illness in immigrant populations.[25] Black and Asian patients are less likely to view themselves as having a psychiatric illness or requiring admission than White patients[26] and a large 2005 study suggested that *"the greater stigma of mental illness in the African-Caribbean community might act as a barrier to early help seeking until a crisis develops, when the behavioural disturbance of the illness is misconstrued by families as requiring legal rather than medical help."*[27]

Furthermore, people from different ethnic groups have different referral and engagement patterns with General Practitioners and the health and care system more generally. The 2002 *Breaking the Circle of Fear* report suggested that poor experiences or perceptions of mental health care lead people from BME groups to be reluctant to ask for help or to comply with treatment, thereby increasing the likelihood of a personal crisis and an involuntary admission. This then reinforces service prejudices and provokes coercive responses, resulting in a downward spiral for the patient (and even greater reluctance to engage with services in the future). They termed this process as 'circles of fear' whereby *"Black people mistrust and often fear services, and staff are often wary of the Black community, fearing criticism and not knowing how to respond, and fearful of young Black men."*[28]

Improving mental health services for BME communities has previously received significant policy attention, through *"Delivering Race Equality (DRE) – an action plan for mental health services."* DRE was in operation between 2005 and 2010 and aimed to achieve equality of access, experience and outcomes for BME mental health patients in England.[29] It also responded to the recommendations of the independent Bennett Inquiry, which highlighted institutional racism in the NHS following its enquiries into the death of David Bennett, an African Caribbean patient who died after being restrained by staff on a medium secure psychiatric unit.[30]

DRE set out a 12 point "vision" of what mental health services should look like by 2010 and triggered a significant amount of work and innovation across the country. This included the development of 18 test sites, exploring new ways of working with BME patients, the recruitment of 450 Community Development Workers, and an extensive programme of research and data collection.[31] Despite this, the findings of the Count Me In Census in 2010 found little change in outcomes for BME patients, with rates of admission and compulsory detention remaining disproportionately high across many BME communities.[32] Stakeholders also expressed frustration that the many local innovations had not translated into a co-ordinated, systemic response across the country.[33]

Since 2010, there has been no targeted national policy aimed at improving mental health care for BME communities and campaigning groups have expressed concern that mental health services lack a sense of strategic direction for reducing inequalities in BME mental health.[34] Many providers have taken action to address these issues, with one example shown in Box 4. Wide-ranging guidance from an authoritative body on the commissioning for services for BME patients is described in Box 5..

The Commission appreciates the importance of the concerns raised by many BME patients and carers – which are often mirrored in the experience of BME staff. It also recognises that these differences have deep seated roots in wider society, culture and history. It believes that in addition to commissioners adhering to the guidance described in Box 5, there is a need for staff induction and training to address racism and cultural and ethnic differences.

The Commission also notes the importance of involving BME communities in planning, providing and monitoring care. One mechanism for this is the Community

Box 4: The Revolving Door Project in Birmingham and Solihull Mental Health NHS Foundation Trust

The Revolving Door training project was developed by Birmingham and Solihull Mental Health NHS Foundation Trust in conjunction with local BME communities.

Targeted at health professionals, the local BME community, statutory organisations, third sector organisations and patients, the project has been introduced to other regions (including London, Brighton, Nottingham and Bradford) and has been further endorsed by the National BME Network.

The training resources aim to enable participants to understand and address the impact of stigma and discrimination relating to mental ill health. Designed around a film that gives participants a community perspective of mental health and mental health provision, the training aims to give the participants skills and strategies to challenge discriminatory attitudes and behaviours about mental health in their places of work and community.

The training was designed by patients working alongside the local community, health professionals, and other statutory stakeholders. Feedback from the training events indicated that an overwhelmingly high number of participants successfully obtained a greater awareness of stigma associated with mental health as a result of the training. An equally high number have identified areas within their practice that can be improved or actions that can be taken within their own communities to address stigma and discrimination.

Development Worker (CDW) role, which was first proposed in the DRE action plan. CDW workers support the empowerment of communities to develop mental health services and identify barriers to people from BME communities accessing services. They also work with communities to build capacity in dealing with mental illness. To date, evaluations of the CDW role in mental health have been mixed, and argue that CDWs need sufficient seniority and clarity of purpose if they are to be successful, and that their roles should allow for a greater focus on community development.[36]

Box 5: The Joint Commissioning Panel for Mental Health guidance on services for Black and Minority Ethnic group patients

The Joint Commissioning Panel for Mental Health published guidance in 2014 for commissioners of services for Black and Minority Ethnic group patients. It recommended amongst other things:

- Commissioners need to fully understand the mental health needs of BME communities, and their experience of the local mental health system. Commissioners also need to recognise that the organisational culture and structure of NHS care can act as a barrier to overcoming health inequalities among BME groups. To gain this understanding, a co-production model for commissioning, procuring, and delivering services should be used.

- Commissioners should identify and implement specific measures to reduce ethnic inequalities in mental health. These include collecting better data, specialist provision, enhancement or modification of existing services, and the scaling-up of innovations.

- [Commissioners] must develop local strategies and plans for improving mental health and wellbeing amongst BME communities.

- Mental health commissioning should recognise the impact of racism, interpersonal violence and conflict on the mental health and mental wellbeing of people from BME communities. Plans must subsequently be developed to reduce the experience and impact of racism and stigmatisation in the community, as well as within mental health services. This is because such experiences can (a) aggravate the course of mental disorder in BME communities and (b) undermine the quality of care of BME patients and carers.

- Some BME groups, such as people of African and African Caribbean origin, may engage better with services specifically designed and delivered to address their needs, and prefer services delivered through community agencies such as BME third sector organisations.

- The quality of mental health care experienced by BME groups depends on the cultural capability of mental health services. Commissioners must ensure that mental health services that they commission are 'culturally capable', in that the service and workforce are able to deliver high-quality care to every patient, irrespective of patients' race, ethnicity, culture or language proficiency. A personalised service response is essential to achieve this objective.

- A long standing concern reported by BME groups is about the disproportionate use of control and coercion within mental health services. Addressing this is key and requires both culturally competent staff and organisations/ systems. Training courses or initiatives on recruitment (ensuring diversity within the workforce) cannot by themselves ensure clinical cultural competency skills. Other methods must be considered including cultural mediation and cultural consultancy services; the 'co-production' of services; development of alternatives to institutional care and increased involvement of BME peer workers and user involvement in the planning and delivery of care; and the presence of spiritual care teams in mainstream services.[35]

The NHS has recently introduced a Workforce Race Equality Standard (WRES, see Appendix 3) which identifies nine measures relating to differences in the treatment of BME staff from the majority population. Each Trust, based on their own results, has to develop and implement a plan for improvement. The rationale is that equal treatment for all members of staff is both good in itself and will ensure there is no discrimination against particular groups of patients.

The Commission proposes that a similar set of measures for patient experience – a Patient and Carers Race Equality Standard – should be developed which can be used to test whether the WRES is having the desired effect as a tool for improvement of services. This should be piloted in a number of mental health Trusts.

The Commission envisages that this Standard should be developed in a similar way to the WRES. It recommends that attention is paid to the lessons learnt from the DRE programme of work. A review of the programme in 2009 found that:

- Data must be measured on a longitudinal basis if ongoing trends are to be measured rather than year on year fluctuations.

- Data should be measured on a regional as well as a national basis.

- Data must be comprehensively collected – there were some gaps in in the DRE data and in some cases data from different organisations could not be compared.

- Differences between ethnic groups can be down to other factors – for example age or gender. A straightforward comparison between BME communities cannot be made.

- Different BME groups need to be engaged and considered separately.[37]

Patient and carer involvement

Throughout its work the Commission frequently heard that patients and carers need to be – and often want to be – more involved in their own care and in the design, provision, monitoring and governance of mental health services.

The 2009 CQC Inpatient Mental Health Survey found that only 34% of patients surveyed felt they were definitely involved as much as they wanted to be in decisions about their care and treatment[38] and many respondents to the Commission's Call for Evidence also reported wanting greater involvement in their care planning. The 2015 report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness has also recently highlighted the importance of involving carers throughout their loved one's involvement with acute mental health services as shown in Box 6.

Box 6: The National Confidential Inquiry's findings about carer involvement[39]

Findings from the 2015 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness suggest that families and carers are an underused resource. The report estimates that greater involvement of the patient's family would have reduced the risk of suicide in 16% of cases in England, (representing a total of 2,338 deaths since data collection began). The report also estimates that incidences of homicide in England could have been reduced if there had been greater contact with families in 18% of cases. Simple measures like contacting the family when a patient misses an appointment (which currently only occurs in around 22% of cases) could improve this.

The Inquiry's 2015 report recommends that services consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans. Staff should also make it easier for families to pass on concerns about suicide risk and be prepared to share their own concerns. This could help to ensure there is a better understanding of the patient's history and what is important to them in terms of their recovery. It follows that it may support better compliance with treatment.

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.

Case studies of such work have been identified by The Health Foundation which illustrated how five UK Trusts have built quality improvement capability that engages all key stakeholders and improves patient experience. Patient safety was at the forefront of one such mental health Trust alongside improving staff and patient experience of the care journey with families. Patients and carers were and still are at the heart of their service improvement, including taking part in staff induction training.[40]

The Commission has heard of many other positive initiatives of patient and carer engagement in the mental health sector but it feels there is still further scope for improvement. In particular it 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. These findings also follow on from previous studies which have found that 80% of patient groups in London were not happy with current arrangements for patient involvement in their Trust.[41]

The Commission noted that many providers were very open to these ideas and that there is considerable experimentation with different models around the country. 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 a wide range of examples where patients and carers are involved in service planning and delivery as well as in decision-making about their own care. These included:

- Care Navigators.
- Peer Support Workers.
- Recovery Colleges.
- Peer managed support houses for respite and crisis care.
- Advocacy.

These are discussed in turn below.

Care Navigators

The Commission understands that Care Navigators have a lot to offer, including supporting patients from BME backgrounds, as they can make relevant links with BME communities to ensure cultural sensitivities are understood and addressed as part of a therapeutic package. Box 7 describes how Southern Health has introduced a Care Navigator post to support staff and provide better coordinated care for patients.

Box 7: The Care Navigator role in the South East area of Southern Health NHS Foundation Trust

The Trust created the role because:

- Having completed a local study on the unit it found that around 36% of nurse time was spent undertaking tasks that could be done by someone else, thus leaving nurses available to spend more time with patients.
- It was evident that a large number of administrative tasks and non-clinical information about a patient's transition through the service was getting lost between handovers.
- There was not always consistent governance for all patients across the acute care pathway; this caused delays and the potential for non-clinical actions to get missed.
- A significant amount of clinical time was being used on finding and co-ordinating beds for admission.

Care Navigators support the team with the safe transition of patients through the acute care pathway by:

Prior to admission:

- Ensuring that the gatekeeping process has been followed.
- Finding and securing beds in the local area or within the Trust.
- Arranging transport.
- Liaising with family members about the hospital site and directions.
- Prioritising any repatriation of patients from out of area placements.

On admission:

- Meeting the patient and gathering social demographic information, plus establishing very early if there are any barriers to discharge.
- Establishing with the patient if they would like to nominate a carer or family member and establishing if they wish to give permission to share information and at what level.
- Requesting if any information is held on the adult social services system in regards to safeguarding concerns.
- Making contact with carers and nominated family members to invite them to a carers' clinic and sending information to them by post.

During admission:

- Attending Multi-Disciplinary Team (MDT) meetings and undertaking administrative tasks that do not need to be completed by a clinician (ie chasing up referrals, housing, care agencies and checking the recording of clustering and Patient-Reported Outcome Measures etc).
- Monitoring whether all parts of the pathway have been completed and alerting the team if elements have been missed (clinical quality is assured by clinicians via a local quality and safety forum fortnightly).
- Arranging meetings for family and carers to attend to meet with the clinical team – (clinical quality is assured by clinicians via a local quality and safety forum which is held fortnightly).
- Monitoring leave beds and patient leave returns to ensure bed availability.
- Maintaining bed usage daily spreadsheets.

At discharge/ transfer:

- Ensuring that patients are safely transferred between services and that the receiving team have engaged with the patient and this has been recorded.
- Arranging transport.
- Ensuring family and carers are aware of plans.
- Ensuring the discharge summary is completed on time.
- Ensuring seven-day follow-up is completed.

Peer support and involvement

The Commssion saw a number of peer support schemes in action and heard about others in existence or being developed around the country. 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'*.[42]

In the UK, mental health workforce policy has identified the potential for peer supporters to fill skills gaps in mental health teams.[43] More recently, a UK mental health policy implementation framework[44] has recommended that mental health services provide peer support as a means of improving recovery outcomes.

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.

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.

A recent systematic review and analysis of all randomised trials (conducted up to 2013) compared community support interventions with and without peer support for people with severe mental illness.[45] The study looked separately at mutual peer support, peer support services and peer delivered mental health services. From the small number of trials conducted and analysed there was little or no evidence that peer support had a positive impact on hospitalisation, overall symptoms or satisfaction with services. This should not necessarily be taken as proof that there is no effect, but simply that it was not evident from the trials conducted so far. There was some evidence that community-based peer support was effective in raising hope, improving recovery

and enabling empowerment, which continued beyond the intervention. There appears to be no similar study on the impact of peer support working within a hospital or residential setting.

This research partially supports the evidence from qualitative trials that participation in peer support as a recipient gives people 'a sense of independence, self-esteem, confidence and empowerment, plus increases social networks.[46] Many commentators feel that increased feelings of empowerment and self-control lead to increased self-esteem, confidence and reduced stigma. These outcomes are felt to be at the heart of personal recovery.[47,48] For peer support workers themselves, the employment increases their chances of further employment and supports their continued recovery.[49]

There has also been a small scale review of trials looking at the impact of introducing peer workers on reducing inpatient bed use. It found a median benefit: cost ratio of 4:1, suggesting very significant potential cost savings associated with the employment of these kinds of staff,[50] although these findings need to be explored further.

It may also be true that that the presence of a peer support worker as part of the clinical team diminishes the discrimination and stigma which exists amongst some staff. The recognition that a peer support worker has a legitimate role increases respect for those individuals and can help staff to reassess their own attitudes. One study has found the contact mental health professionals have with people with mental illness is associated with positive attitudes about civil rights, but does not reduce stigma in the same way as social contact such as with friends or family members with mental illness does.[51] Further research is needed to determine whether or not contact with colleagues who have experienced mental health issues would have similar effects to contact with close social contacts.

A study of more than 1000 papers by Nesta and National Voices has summarised the evidence to examine whether peer support works in a variety of health conditions.[52] They found that for people with long-term health issues, mental health problems and 'at-risk' groups, peer support improved their experience, improved health behaviour and outcomes and improved service use and costs. They also found that different types of peer support may have varying benefits, but the most promising seemed to be:

- face-to-face groups run by trained peers which focus on emotional support, sharing experiences, practical activities and education.
- one-to-one support offered face-to-face or by telephone.
- online forums, particularly for improving knowledge and anxiety.
- support offered regularly (such as weekly) for three to six months.

This discussion suggests that further research is needed specifically:

- Into the effectiveness and efficiency of peer support, specifically its potential to reduce inpatient bed use, through well-designed randomised controlled trials in order to understand whether or not they confirm the results of earlier studies.
- To determine the factors which make peer support most effective.
- To investigate the potential of peer worker support in reducing stigma for patients and reducing stigmatising attitudes amongst mental health workers.

Recovery Colleges

Recovery Colleges (see Box 8) use specialist peer workers to 'co-produce' courses with staff aimed at educating people about their conditions and providing support for self-management. Education and self-management are important components of clinical guidelines,[53,54] and an effective way to promote empowerment.[55] They are seen as a core element of improving patient experience within adult mental health services.[56] The commissioning of active support for self-management is identified as the top priority for commissioners in transforming the healthcare system in England.[57]

Box 8: Dorset Recovery Education Centre

The Dorset Recovery Education Centre (REC) has been running for just over three years and has approximately 2000 registered students. The Dorset REC is delivered in partnership between Dorset Mental Health Forum (a local peer-led organisation) and Dorset HealthCare University NHS Foundation Trust. All of its courses are co-produced and co-delivered between Peer Specialists and Professionals.

Dorset REC is open to anyone aged over 18 who lives in Dorset, but is marketed at patients who access secondary mental health services. Students therefore come from a range of backgrounds including people who access services, carers and supporters and staff. This shared learning environment is important as it enables everyone to learn from each other. People are able to access education once discharged from services or if people fall between services. Every student has an individual learning plan, which includes how they will self-manage during the course and helps signpost people to further activities or support.

Courses are focused on people exploring what recovery means to them and developing skills to manage their own wellbeing. Examples include: Self-Management, Coping in a Crisis, Early Warning Signs, Understanding your Values, Medication: Choices and Options, Recovery for Carers and Supporters. The feedback from students is on the whole overwhelmingly positive, in particular having the peer perspective and professional perspective. Students identified that they felt a greater sense of hope and acceptance, that they were better able to self-manage and had better relationships.

The REC provides the opportunity for people to develop skills to learn from their experiences of crisis. It also enables people to identify strategies for people to avoid crisis or cope more effectively, and gives staff and carers the chance to learn how to support other people better.

In 2015 Dorset REC was shortlisted for the HSJ and Nursing Times Patient Safety Awards.

Peer managed support houses for respite and crisis care

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. Box 9 describes one such facility designed specifically for women. 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.

Box 9: Drayton Park Women's Crisis House and Resource Centre

Drayton Park is the first women-only residential mental health crisis facility in the UK.

Drayton Park provides up to 12 women experiencing a mental health crisis with a residential alternative to acute admission. It also offers non-residential services for women who have stayed previously, such as support groups, peer support and a range of workshops.

Children can be admitted with their mothers and this is discussed on an individual basis at the point of referral.

The Drayton Park team work closely with residents' General Practitioners and identify and address concerns regarding physical health problems. The staff are all trained to explore disclosures of past or current traumas such as sexual, emotional or physical violence in a psychologically safe environment, offering a range of techniques and tools so residents feel better prepared to manage any future crisis.

Accepted patients are offered a one week stay initially and this can be extended up to a maximum of four weeks. Residents have access to an all-women team 24hrs a day who offer formal support such as daily one-to-one sessions, and informal support such as company at mealtimes or assistance with washing or making telephone calls. The team also support residents to take any prescribed medication correctly and to access repeat prescriptions or reviews of medication as necessary.[58]

Drayton Park was evaluated by Killaspy *et al* in 2000. This study concluded that:

Drayton Park has succeeded in its aim of providing a safe alternative to hospital admission for those who experience acute mental distress and admits women with severe mental health problems. The involvement of service users in the planning and management advisory group has helped the project to incorporate an alternative approach to crisis resolution and its innovative style has aroused both national and international interest. Future evaluation of this service including the unique facility it offers to women with children is planned.[59]

Advocacy

"Advocacy movements [in mental health] emerged as a response to the recognition that people with mental disorders were especially vulnerable to serious human rights violations, especially to involuntary long-term detention in psychiatric institutions. Most of the earliest advocacy organisations were created by close family members of people with mental disorders. Subsequently people with mental disorders began to form their own organisations to advocate for their own interests."[60]

The right to mental health advocacy for people subject to the Mental Health Act is now a legal requirement, resulting from a prolonged community campaign to promote the rights of psychiatric patients as a moral and ethical human rights requirement.[61,62]

Despite this, the Care Quality Commission has raised concerns over the current provision of advocacy services and has found that many Local Authorities are not conducting adequate needs assessments prior to commissioning advocacy services. This means that services may not adequately provide for some patients, in particular those from BME backgrounds.[63] The Mental Health Alliance has also found that many services are underfunded and overstretched and that many patients and staff still have a lack of awareness of the role of advocacy in mental health.[64]

The Commission is concerned by these findings as it has heard of the vital role advocacy services play throughout the course of its work. Box 10 describes one of the more advanced peer advocacy schemes in the United Kingdom which combines elements from the different approaches discussed in this chapter.

Box 10: 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.

Recommendations

There is a great deal of good work going on around the country addressing the concerns of patients and carers and engaging them fully in planning and services. There is, however, much more to be done here and in addressing the specific needs of people from Black and Minority Ethnic communities. These two recommendations are designed to accelerate progress in both areas.

8 Patients and carers are enabled to play an even greater role in their own care as well as in service design, provision, monitoring and governance.

This will involve providers, with support from commissioners and other partners:

• Working with patients and carers to further develop their involvement in all aspects of the organisation.

• Ensuring that patients and carers involved in these activities receive the training, development and support they need to do so.

• Evaluating programmes and sharing good practice and learning both within their organisation and more widely.

9 A *Patients and Carers Race Equality Standard* is piloted in mental health alongside other efforts to improve the experience of care for people from Black and Minority Ethnic communities.

This will involve NHS England and NHS Improvement working with patients and carers groups, NHS Providers, the NHS Confederation Mental Health Network and the Royal Colleges of Psychiatrists and Nursing to:

• Identify a clear and measurable set of Race Equality Standards for acute mental health services by October 2016 and piloting them in a selection of Trusts from April 2017.

• Set up monitoring and public reporting processes for all Trusts from April 2018.

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15. Terminology: This report builds on the definition used by the Joint Commissioning Panel for Mental Health. 'Black and Minority Ethnic (BME) groups' are therefore understood as encompassing:
   – people living in England who are designated as belonging to a non-dominant ethnic group (according to national Census criteria)
   – which represent distinct groups
   – and with their own identity recognised by themselves and by others
   The Commission is mindful that it is crucial to:
   1 distinguish between commonly conflated concepts of race, culture and ethnicity, whilst acknowledging the significance not only of race but of having 'a cultural heritage distinct from the majority population'
   2 avoid aggregating all ethnic groups together where possible.
   This briefing has adopted the terminology found in each of the original sources that it cites.

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06

Information, outcomes and accountability

Summary

This chapter reviews the current collection and availability of information both locally and nationally and considers how improvements here could enhance the functioning of the whole mental health system. It also describes the need for greater openness and accountability.

It argues that information needs to be turned from being a problem into a central enabling and organising feature of an effective mental health system and makes recommendations for developments both nationally and locally.

Information collection and availability

Time and time again people told the Commission about the need for better information in mental health and the Commission was struck by its own experience of how difficult it was to obtain information about key aspects of the system. Some information is simply not collected at all, whilst much that is collected goes to waste as no coordinated mechanism exists to draw upon it at either a local or national level. This lack of information not only inhibits good planning and operational management but is also an enormous wasted opportunity to bring the whole system together and enable it to function more effectively.

As noted in Chapter 3, the mental health system is complex and fragmented. The Commission argued there that there is a need to introduce better coordination for the whole system in an area, understand it better, simplify it wherever possible and create more joined-up processes and systems. High quality shared information, preferably available in real time, is an essential part of an effective system. Rather than being a problem, as now, the open flow of information and communication should be a central organising principle for the whole system – both locally and nationally. Access to and use of these systems will bring people from different parts of an organisation and from different organisations together around the same problems and the same solutions.

The Commission considers that commissioners, providers and their partners in every area need to be able to easily find the number and type of specialist and non-specialist inpatient beds in their area, the number and types of community services available, and the provision of housing and other services. They also need data on patients, usage, throughput, occupancy, out of area transfers and much more. The absence of this essential information makes it almost impossible to make high quality decisions about many aspects of patient care and the deployment of staff and resources.

Similarly, at the national level there is a need for better information about activity, outcomes, staffing and costs so that national bodies can undertake their responsibilities properly whether in workforce planning, commissioning, scrutiny, regulation and providing accountability to the public and Parliament.

There are too many issues which need to be addressed here for the Commission to tackle, many of which go far beyond its terms of reference. It has therefore confined itself to considering three major areas where progress needs to be made before there can be much progress in other areas. These are:

- The development of good operational systems locally.
- The creation of a coordinated national resource of information largely built up from data captured through local operational systems.
- The development of an outcomes framework based on the existing Mental Health Minimum Data Set.

In the longer term this structure can be extended and developed to enable better collection of data on diagnoses and outcomes and to ensure that all staff have access to evidence-based decision support systems as and when they need them. In the short-term, however, systems need to be developed which will enable clinicians and managers to improve the functioning of the mental health system in their area. These should be underpinned by the principles that the views of the people using the service are key, and that there should be no measurement without direct clinical utility.[1]

The current situation nationally

There are several national sources of data available which the Commission has used, including the Health and Social Care Information Centre (HSCIC), Public Health England, the Mental Health Information Network, NHS Benchmarking, Monitor and the Care Quality Commission. Much of this is high quality, however, there are many topics not covered. Moreover, as noted later, some national collections have been stopped in recent years. The three following examples concerning prevalence, human resources and finance reveal some of the problems with the current situation.

The Mental Health, Dementia and Neurology Network currently publishes data online via Public Health England on the prevalence of common mental disorders and serious mental illness.[2] There are, however, gaps in what is available: the only prevalence information published for serious mental illness, for example, is the estimated prevalence of new psychotic episodes. This ignores other serious mental illnesses such as bipolar depression or severe unipolar depression. Moreover, some of the data presented is not of high quality: for example, of the twenty pieces of data published showing prevalence of common mental disorders only four are described as being 'robust', and nine are described as having 'significant concerns' associated with them.

Turning to workforce issues, between 2005 and 2010 the NHS Information Centre for Health and Social Care undertook a mandatory survey of employers and published three-monthly vacancy rates for NHS posts. It also published "all vacancy" rates between 2008 and 2010. The HSCIC has recently begun again to provide some statistics on vacancies. However, these are based on published vacancy adverts obtained from NHS Jobs - the main recruitment website for the NHS – and represent the number of adverts (some adverts may be for multiple roles) rather than the number and actual nature of vacancies. This data is simply inadequate for monitoring employment rates across the NHS and independent sector in order to inform workforce planning.

A recent report strongly criticised the inadequacy of current workforce data collection, noting that *"there are large data gaps on key areas of the workforce, particularly primary and community care, use of agency and bank staff, vacancy rates, and independent and voluntary sector providers. The information needed to guide workforce planning at local and national levels has failed to keep pace with the growing plurality of providers delivering NHS-commissioned services."* [3]

Some of the same problems affect finance. Until 2012, for example, it was possible to identify expenditure on adult mental health services separately from total spend via the annual financial mapping process undertaken by Mental Health Strategies on behalf of the Department of Health, and which has since been discontinued. The Commission understands that the Department of Health's view is that it has been replaced by programme budgeting and reference cost data. However, the Commission has been told that this is simply unrealistic as the formats of those collections are too general to enable comprehensive analysis to take place, and the guidance is too uncertain to be confident that like is being compared with like throughout. This is apparently particularly true of the reference cost data, which are based on care cluster pathways, and highly variable as a result.

There are also problems with definitions. It was noted in Chapter 2 that the Commission's survey found an average of 16% of people in inpatient wards were ready for discharge. This methodology contrasts sharply with national performance figures collected by NHS Benchmarking which recorded that that delayed discharges accounted for an average of 4% of bed days being lost for each Trust in 2014/15.[4] This latter count uses a definition of a 'Delayed Transfer of Care' (DToC) based on when certain processes have been completed and an overall assessment of safety as described below.[5]

A DTOC occurs when a patient is ready to depart from acute mental health care and is delayed. A patient is ready for transfer when:

- A clinical decision has been made that a patient is ready for transfer, and
- An MDT decision has been made that a patient is ready for transfer, and
- The patient is safe to discharge/transfer.

This definition, like the Commission's own survey, is very subjective and depends on people locally making judgements. The key point here is that Trusts need to make regular assessments of when and why delays occur in order to address them. Some Trusts make an

assessment at the time of admission of how long a person may be in inpatient care before discharge. They then investigate each time that a patient stays longer than this period.

It is also worth noting that the definitions used for particular services – Assertive Outreach or Early Intervention in Psychosis for example – are not consistent throughout the country. These could easily be standardised by adopting the definitions proposed by the NHS Confederation Mental Health Network.[6]

The current situation locally

There is enormous variation in the availability and use of information locally. The Commission observed or was told that:

- Some providers do not have basic information available electronically about the patients that their different services are treating – such as age, gender, ethnicity or detention status.

- Many providers did not have data available on the diagnosis of their patients. They were not, for example, able to identify the numbers of patients with personality disorders being admitted. Such data can also provide warning signs about local service composition – for example if an unusually high number of patients with personality disorder were being admitted to acute inpatient units (as compared to the local prevalence) then this could indicate that local community services for personality disorder are underprovided.

- In many instances data related to one patient's care has to be inputted to several different electronic systems (and sometimes a paper record is also made).

- There is often poor expertise in mental health informatics locally and commissioners do not always draw on the data that is available to help them undertake their work.

- Some clinicians spend significant amounts of time inputting data, which is not analysed and fed back to them (thus causing resentment).

Perhaps most importantly of all, there is little data shared across whole local systems so that everyone is able to see the same information and share in planning and decision-making on the same basis. This is crucial in making the system function effectively.

Some providers and whole local systems have, however, developed their own systems – with some of them making real time information available to their staff and other groups – and are seizing the opportunity to make information a central enabling and organising principle within their whole system.

Box 1 describes how 5 Boroughs Partnership NHS Foundation Trust (in the northwest of England) has developed a system which allows staff to find crucial operational information at a glance.

Box 1: 5 Boroughs Partnership NHS Foundation Trust Patient Status at a Glance System

Patient Status at a Glance boards (PSAGs) were first introduced in 2012.

The PSAG board is run through an access database which can be digitally displayed. The database itself holds an interchangeable set of features which can be accessed via different views. The overall ward view displays risk ratings, demographics, key contacts and legal status.

All members of the Multi-Disciplinary Team (MDT) who routinely input into clinical work have access to the PSAG. The data is live and the PSAG can be viewed via the main function on the digital smart board or via individual computers. Practitioners such as consultants and pharmacists who are based off the ward are now in a position to add clinical tasks or request specific investigations assessments or interventions from their own office space. Likewise they may view tasks or patient requests which are specific to them in the same way. This allows for greater continuity and is more time efficient. A 'traffic light' system is utilised.

The latest development is a Cardiometabolic Screen page, which has various fields relevant to the health of the patient's heart and their risk of cardiovascular disease. In addition to basic information such as height, weight and BMI the form asks questions relevant to the patients 'QRisk' status such as whether there is a history of angina or heart attacks in their immediate family, family history of kidney disease and atrial fibrillation. The results are fed into the QRisk2 website which determines an overall risk of heart attacks or stroke. The page also collates information on both smoking and alcohol intake.

Different elements can be viewed as follows:

The Patient View

The Patient View allows individual clinical journeys to be mapped in more detail. There is a visible display of data containing fields of information such as consultant, age, length of stay, patient identifiers, named nurse care coordinator, social worker, legal status, safeguarding alerts, and admission stage. This is accompanied by seven clinical subcategories: Assessments, Referrals, Risks, Investigations, Interventions, Reviews and Health. At a glance, practitioners are alerted to any outstanding actions, high risks or health alerts.

Figures are representative but not exact replications of the originals

Safeguarding

Each Patient View has a safeguarding rating to indicate any potential safeguarding concerns. Safeguarding actions can be selected from a drop down menu and then added as a quick task.

Assessments

Once a patient is admitted the database will automatically populate each clinical sub-category with required actions. There is an option to add other assessments from a drop-down tool bar should they be deemed clinically necessary.

Box 1: 5 Boroughs Partnership NHS Foundation Trust Patient Status at a Glance System (continued)

Referrals

Referrals are determined in response to clinical need. If the MDT feel specific referrals are required they can be added to this section.

Risk

The risk section is again reflective of each patient's clinical presentation. This section is populated by Nurse Practitioners in response to a comprehensive risk screen and risk assessment. Risks are listed by type alongside a colour-coded status of either High, Medium, Low or Historic.

Investigations

This section is pre-populated with required investigations such as blood tests. There is an additional option to add other investigations from a pre-populated drop-down box and an option to add required investigations as 'quick tasks'.

Interventions

Interventions are to be determined and listed in response to clinical need. There is a pre-populated drop-down tool which lists frequently used interventions such as anxiety management, hearing voices groups and weekly activity planners.

Reviews

The Reviews section is automatically populated with 72 Hour Review, Care Plan Review, Risk Management Review and Named Nurse Review. Once initial reviews are complete further review dates are automatically scheduled.

Health

The Health Section is used to identify any significant health problems a patient may have. The status attached to a health problem reflects whether or not the problem is acute or managed.

Tasks

Tasks are rated as either 'incomplete," in progress' or 'complete'.

Data and information systems can be used operationally to improve services and access. Box 2 gives an example of how taking a new approach to information collection has led to major service and cost improvements in Northumberland Tyne and Wear. The new single point of access is enabled by the introduction of new data collection and communication systems.

Box 2: Northumberland Tyne and Wear NHS Foundation Trust's Urgent Access Model

In 2011 the Trust took action in response to its triage line being saturated by calls. Overnight and at peak demand times callers could wait hours for a return call from a clinician. Fewer than 35% of referrals needed admission/ home treatment; most referrals required advice/signposting and were at low risk/acuity.

A new Urgent Access Model was developed in response to this, whereby all referrals are made to a single centre via a single telephone number, where they are immediately triaged and managed. The Urgent Access Model differs from other/traditional arrangements for urgent access in that it is available 24 hours a day, seven days a week with no restrictions on who can make contact for the purposes of referral. The service covers all ages and people with learning disabilities.

As well as enhancing the Trust's capability to take calls, new resources were provided so rapid face-to-face triage could take place in the community when it could not be fully completed over the phone. Key crisis and home-treatment resources and teams were protected, with flexible joint-working arrangements between Crisis/Access functions.

The Urgent Access Model is supported by the adoption of digital solutions such as 3G-enabled mobile laptops to access notes, digital dictation and transcription via mobile phones.

Box 2: Northumberland Tyne and Wear NHS Foundation Trust's Urgent Access Model (continued)

Typical *weekly* activity:

- 3000+ incoming telephone calls.
- 1500 total contacts (individual patients).
- 500 home-based treatment contacts.
- 60 crisis assessments.
- 150 rapid responses.
- 90% of calls are answered within 15 seconds.
- > 98% are answered within 3 minutes (average = 9 seconds).
- > 80% rapid responses are achieved in under one hour.

An evaluation of the new model is currently underway, and early analysis suggests:

- Enhanced urgent access triage capacity markedly improves the accessibility and responsiveness of the access/triage service.
- The enhanced Urgent Access Model receives very positive feedback from patients and carers.
- Compared to a similar area without enhanced access, the systems and resources seem to reduce total numbers of urgent/acute admissions.
- Compared to a similar area without enhanced access, the systems and resources seem to result in more rapid falls in length of stay for those who do get admitted.
- Compared to a similar area without enhanced access, the systems and resources seem to reduce total bed usage.
- The savings from reductions in bed-usage markedly outweigh the additional recurring costs of the access system (approx. £2-3 reduced bed costs for £1 on Urgent Access systems).

Outcomes and accountability

It is very difficult to obtain a good picture of how a Trust is performing against key indicators in part because it is not clear what all the relevant indicators should be. The Mental Health Minimum Data Set covers some of them but this does not include the sort of standards described in Chapter 4 and in Recommendation 6. Moreover, there are many outcome measures available for use in adult mental health.[7] The Mental Health Minimum Dataset mandates the use of the Health of the Nation Outcome Scale (HONOS). However, there are some concerns about it. It has been pointed out for example that it is not sensitive enough to capture changes in some patients,[8] and the 'catchall' nature of the measure may limit its utility in comparing the outcomes of patients with different conditions. Additionally, only 9.8% of care spells between April 2013 and March 2014 had two HONOS assessments completed at some point. The absence of assessment means that neither improvement nor deterioration can be tracked.[9] It is vital that services record pre- and post-intervention scores; these paired scores must then be immediately accessible.

The Commission proposes that the Minimum Data Set should be reviewed and converted into a set of measures which can be used to represent the overall performance of a Trust. This will be helpful not only in providing clear direction for Trust Boards and management but also as a means of accountability to the public and for comparison nationally across all aspects of care and performance in patient outcomes and patient and carer experience.

This approach to measuring performance and outcomes in as near to real time as possible so as to affect decision-making is already happening in some areas such as the Improving Access to Psychological Therapies programme (IAPT). The HSCIC notes that *'this data is used by patients and IAPT workers to provide tangible evidence of treatment progression and by supervisors to review clinical work. It is used by managers to facilitate effective service performance and by service commissioners and others to demonstrate the direct return on the investment made in services, benchmarked against clear performance measures.'*[10]

Figure 1 deals only with measures and outcomes concerning a patient's experience within an individual Trust. It will be important in the future to address outcomes for the whole patient pathway, rather than just that part covered by individual providers. An initial step in progress towards this will be the development of shared information systems across commissioners and providers within a location.

Spreading this approach will require better use and availability of technology – recording progress for example via text messages or an app that links with the patient's electronic patient record. Digital dictation and a 4G-enabled laptop with access to electronic patient records would mean that they could be updated in real time, so that teams always make decisions based on the most up-to-date information.

Figure 1: Trust Board Integrated Corporate Dashboard, Dorset Healthcare University NHS Foundation Trust

Data source: Dorset Healthcare University NHS Foundation Trust

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Figures are representative but not exact replications of the originals

Future opportunities

The Commission believes that it is imperative to address the three issues of local operational data, national collection and the development of the Minimum Data Set 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:

- Making evidence and decision support available to clinicians.

- The use of information systems in the management of individual patients.

There is currently considerable variation in the application of NICE guidelines to mental health services as elsewhere.[11,12,13] 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:

- 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.

Recommendation

The Commission has constantly been reminded throughout its work that it is essential to improve data collection and the use of information both nationally and locally in order to improve services and accountability. There is an enormous amount that needs to be done and the Commission is aware that NHS England and others are working on developments in this area. It recommends here only the initial steps that need to be taken to start on the long-term and far-reaching developments that are needed.

The commission recommends that:

10 The collection, quality and use of data is radically improved so it can be used to improve services and efficiency, ensure evidence-based care is delivered and improve accountability.

This will involve:

- The Department of Health and NHS England bringing nationally available information together into a single resource adding to it as necessary to support operational management locally.

- The Department of Health, with NHS England and NHS Improvement leading a review of the Mental Health Minimum Data Set to ensure its fitness for purpose for monitoring and evaluating acute care pathways and converting this into a publicly available set of performance measures that enable local and national analysis of the state of acute mental healthcare and the outcomes being achieved. This work must include review of the current Delayed Transfers of Care definition and data collection system which is not fit for purpose.

- Commissioners and providers collaborating to develop local operational systems which will allow for sharing of critical information and help the whole system work more effectively.

- Providers developing their internal systems to provide open real time information to their staff and, in the longer term, ensuring that evidence as well as care pathways and protocols are available to all relevant staff where and when they need them.

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07

Leadership, culture and staffing

Summary

This chapter describes the difficult position that mental health services face in terms of staffing, recruitment and morale, whilst noting that these problems are not universal and that there are many highly motivated and high performing teams around the country. It stresses the central importance of leadership and culture as well as the need for development and training.

It recommends that organisations promote leadership development and an open and compassionate culture with particular reference to better ward management, values-based recruitment and staff training and development.

Staffing, vacancies and recruitment

Mental health faces a generally difficult position in terms of staffing levels and recruitment. There are significant regional variations, however, with much better retention rates for staff in the north and far higher turnover and use of agency staff in London. The discussion of data here is, as elsewhere, made much more difficult by the lack of national data as discussed in Chapter 6.

The Royal College of Nursing calculate that the number of full time equivalent (FTE) mental health nurses employed in NHS-provided services fell from 41,320 to 38,055 – a loss of 8%, equivalent to 3,300 FTE nurses – between September 2010 and July 2014.[1] Data from a similar dataset for 2009-2014 indicates that this trend seems particularly pronounced in inpatient psychiatric settings, where the number of FTE nurses fell 15% in the five years studied.[2]

The Commission notes that some of this decline may be accounted for by nurses transferring to work in voluntary or independent sector providers, providers, which the Commission understands currently account for approximately one-fifth of mental health provision in England. It is hard to tell how much of the decline can be attributed to this because the HSCIC only publish data on NHS *provided* services and not NHS *commissioned* services but the increase in independent and voluntary sector provision is unlikely to be able to account for the full decline in nursing numbers. The lack of data also makes it difficult for Health Education England to plan future workforce needs as they need to plan based on the whole workforce, not just the NHS element.[3,4]

The decline in numbers of mental health nurses also stands in contrast to the number of nurses in physical healthcare settings where overall numbers of nursing numbers have increased by 1% since 2010. This is partly linked to the impact of the Francis Report. This has had the unintended effect that mental health services have had to implement proportionately greater efficiency savings than physical healthcare Trusts which have had to implement the Francis Report recommendations.[5] These reductions mean that overall the mean vacancy rate on adult acute wards in 2014/15 (across all staff groups) was 14% with a range of 2%-32%.[6]

The Commission notes that the number of requests for agency staff of all types by mental health Trusts has risen by two-thirds since 2013.[7] The sums involved vary considerably, and are significant in many cases. Between Q2 2012/13 and Q2 2014/15 spending on agency nursing staff went up in 35 of the 45 NHS mental health Trusts surveyed (77% of those with data). Agency spend in Q2 2014/15 varied from £2,750 to £3,506,186 with an average Trust spend of £817,700.[8] NHS Benchmarking data shows that Trusts spent an average of £12,376 on bank and agency staff costs per adult acute bed in 2014/15.[9]

The position with doctors is more positive. Data from 2014 from Health Education England indicate a 6.3% vacancy rate for NHS consultant psychiatrist posts,[10] whilst the Royal College of Psychiatrists' census data from 2013 showed a rate of 4.8% vacancies for general adult psychiatry specifically.[11] Additionally, the number of trainees progressing into a Core Training post in psychiatry has increased from 4.7% in 2012 to 5.7% in 2014. Moreover, most medical schools are moving towards the national target of 7.5% of posts in both years of Foundation training being in psychiatry, with the aim being that by 2017 45% of Foundation doctors will have undertaken a placement in a psychiatric setting. This is important as there is evidence that the more exposure medical students and young doctors have to psychiatry, the more likely they are to choose it as a career.[12,13] It is of some concern however that only 72% of Foundation doctors express satisfaction with their psychiatry placement, lower than in many other specialities.[14]

There are significant workforce problems in mental health social care. Not only is there a shortage of social workers in mental health services, but it has also been suggested that the quality of applicants and trainees is not uniformly high. Additionally, the vast majority of trainee social workers (92%) do not complete a mental health placement as part of their training.[15]

The number of full-time equivalent clinical psychologists in the NHS increased by 27% between 2004 and 2014. The number of staff delivering psychological interventions increased by 398% (from 723 to 3,599) in the same time period.[16] It is impossible to determine how many are working in acute mental health and it is likely that the expansion in psychotherapists is due to the development of the IAPT programme.

Mental health suffers to some extent from a poor image which affects recruitment and which the Royal College of Psychiatrists and others work to dispel.[17] There also appears to be a considerable amount of stigma associated with working in inpatient settings as compared to community teams. Many nursing staff in particular perceive inpatient work as being the first step on a career ladder which progresses to community settings. This manifests itself in a high turnover of staff in some services, with staff leaving as soon as they have accumulated the skills and experience to move to more desirable community roles. The lower status of inpatient wards is thought to reflect the higher acuity of patients' symptoms and the commensurate pressure that this puts on staff. Paradoxically, this acuity and pressure suggests that inpatient care should really be the 'top rung' of the nursing career ladder.

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.

There are many good examples nationally and locally of leadership development schemes. 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. There is also a need nationally to develop more leaders form Black and Minority Ethnic communities.

The relationship between staff satisfaction and patient outcomes

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.

Staff morale and wellbeing impact directly on patient care. Writing in the 2010 NHS Quality and Staff Engagement report, West and Dawson noted that: *"Where staff have clarity of purpose they provide good quality care... Leadership by senior managers and immediate managers helps to ensure clarity of purpose and it is not surprising that when staff see their leaders in a positive light that this is strongly related to patients' perceptions of the quality of care they receive... There is a spiral of positivity in the best performing NHS Trusts. The extent to which staff are committed to their organisations and to which they recommend their Trust as a place to receive treatment and to work is strongly related to patient outcomes and patient satisfaction. Climates of trust and respect characterise these top performing Trusts"*.[18]

How the mental health workforce feel about working in the service therefore has a direct and immediate effect on patient care, patient satisfaction and patient safety. When staff are fire-fighting and reacting to events then feelings of disempowerment rise and motivation can fall. The Francis report acknowledged that there was a culture of fear in many teams and institutions, and that 'name, shame and blame' remained very common.[19] This significantly impacts on wellbeing, and ultimately on patient care.

This evidence shows that improving the health and wellbeing of staff – treating staff with dignity and respect as well as paying attention to their training and development needs – increases staff morale and in doing so reduces deaths and saves money. Every standard deviation point of improved engagement in an organisation is estimated to cut salary costs by £150,000 and reduce the number of deaths by 2.4%.[20]

Job satisfaction and morale

Studies of job satisfaction and morale in mental health Trusts present a worrying picture overall – although not in all organisations as there is very big variation between employers. The annual NHS staff survey for 2014 found that for staff working at mental health Trusts:

- 41% agreed/strongly agreed that in general their job is good for their health. 28% disagreed or disagreed strongly that in general their job is good for their health.

- 15% reported having experienced physical violence from a patient or patient's relative in the preceding 12 months.

- Only 45% believed that their organisation takes positive action on health and well-being.

- 20% reported feeling under pressure to come to work in the last three months despite feeling unwell.

- 43% reported that during the last 12 months they have felt unwell as a result of work related stress.[21]

This set of findings is supported by the results of the NHS Friends and Family Test for Staff. The latest results for April-June 2015 showed that across mental health Trusts on average only 62% of staff would recommend their Trust as a place to work, whereas 20% wouldn't.

Turning to inpatient wards specifically, a 2011 national study of staff morale amongst inpatient mental health staff found that in general staff reported fairly good job satisfaction and a sense of achievement from their work. However, there were large variations between types of ward both in terms of emotional exhaustion and GHQ (General Health Questionnaire score, a standardised instrument that identifies minor psychiatric disorders). Generic acute ward staff showed most sign of stress: a very worrying 49% met the threshold for burnout on the emotional exhaustion scale. In addition nearly a quarter of the sample reported that they had been bullied in the past year and just over half said that they had experienced

discrimination. The most frequent form of discrimination was on the grounds of ethnic background, and 54% of Black African or Caribbean staff reported discrimination – with patients the most frequent source.[22]

In general the Commission noted substantial differences what it was told by different groups of staff about their experience. Some seemed to have very high motivation and morale while others appeared to be very demoralised and, even, despondent about their work and the future. This paralleled the divide in culture and atmosphere between being "trapped" or liberated" as described in Chapter 4.

Staff from Black and Minority Ethnic communities

Evidence suggests that there are particular problems with morale amongst people from a BME background. It has been suggested that this is in part due to systemic discrimination against BME staff within the NHS, which has been highlighted in numerous reports. These reports show that by every indicator BME staff experience less favourable treatment when working in the NHS than their White colleagues.[23]

Being undervalued and discriminated against can lead to disengagement, unhappiness, depression, poor performance and ultimately reduced effectiveness. Though this appears true for all groups, there is a particular relationship with ethnicity: *"The staff survey item that was most consistently strongly linked to patient survey scores was discrimination, in particular discrimination on the basis of ethnic background."*[24]

There is a good link between the treatment of BME staff and patient satisfaction: *"The greater the proportion of staff from a black or minority ethnic (BME) background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction. The experience of BME staff is a very good barometer of the climate of respect and care for all within NHS Trusts"*.[25]

13.6% of medical, non-medical and support staff working in the NHS are from a Black or Minority Ethnic group background,[26] yet the Commission notes that there are very few people from these backgrounds at the most senior levels. Looking outside health, a recent report concluded that companies in the top quartile for racial and ethnic diversity are 35% more likely to have financial returns above their respective national industry medians.[27]

Development and training

The difficulties described here make a strong case for Trusts to pay particular attention to the needs of their staff. In particular, the Commission would encourage employers to review both the staff/skill mix and the training and development of ward staff. Many patients and carers, as noted earlier, complained about the lack of structure and activity in wards. This reflected in some cases an absolute shortage of staff but in others was more to do with the mix of staff and their skills, training and development. Time spent on inpatient wards needs to be purposeful and focused on recovery and the activities available need to reflect this. The intention must not be, however, to extend the time on wards so that patients can receive therapy there but to ready them to continue their recovery in a community setting where they will be likely be able to progress more quickly.

NICE have produced a suite of evidence-based guidelines covering the majority of conditions relevant to adult acute psychiatric care. However, many patients are not receiving care concordant with the appropriate guideline,[28,29,30] and the Commission heard that in many cases this is because staff do not have the requisite skill set. It is therefore vitally important that services review whether patients are receiving NICE-concordant care as part of the *service capacity assessment and improvement programme* described in Chapter 2, and take corrective action if an inadequate staff skill mix is preventing this.

Not all of the review of skill mix should be focused upwards. The Commission also saw many examples where less qualified staff members, some in new and specific roles such as Care Navigators, were able to make very significant contributions to services. In all cases, however, success was dependent on good planning, appropriate job descriptions and recruitment as well as on training, supervision and integration into a team. These are all necessary elements in making the most of all the talents available to ward managers and other leaders.

The recommendation in Chapter 5 about promoting the greater involvement of carers and peer support workers should mean that there are more people available on wards to interact with patients and make them more interesting environments. Clinical professionals and ward managers in particular should see themselves – like others working in health – as being in part agents of change who

lead and facilitate others to provide services.[31] It was clear from site visits that this was what many successful ward managers do in reality.

The Commission noted that managing an acute admission ward is a highly complex and challenging role and the recruitment and development of people in these roles must be a priority for Trusts. It noted that some Trusts had very successfully appointed people other than nurses to these roles, recognising that the skills needed were not the province of any single profession. It also noted that, whilst salary is not the overriding issue, nurses in particular can earn the equivalent salary to a ward manager – with less stress, less responsibility and more job satisfaction and the same or even better pay. There is a case for reviewing ward managers' pay to ensure that these roles are recognised for their true importance.

This is particularly important at a time when the loss of nursing roles seems to be disproportionately affecting higher band nurses, with significant falls in the numbers of Band 7 and 8 nurses particularly. The RCN has argued that this reflects how *"senior nurses are being downbanded or losing their jobs, and being replaced with nurses on lower bands or health care assistants who cannot offer the same skills as those on higher bands. The RCN believes that in many circumstances, this downbanding is due to the need to reduce the overall pay costs rather than for clinical reasons".*[32]

There are many important areas where training and development may need to be enhanced in different organisations including, for reasons that flow from earlier discussion, in developing skills in quality improvement, for working with people from other backgrounds and cultures, and working in partnerships with other organisations.

A culture of compassion

Many people have commented on the need for compassion and the importance of wards being, as far as possible, inviting and friendly places. Several Trusts have incorporated this in their approach to values-based recruitment – where alignment with the Trust's values is an essential characteristic for everyone appointed to the Trust whether they are health care assistants, consultants or the Chief Executive. These values need to be further reinforced through induction, training and the normal work activities of the organisation. Box 1 gives an example of values-based recruitment.

Box 1: Values-based recruitment

Northumberland, Tyne and Wear NHS Foundation Trust now uses 'values-based recruitment' for all nursing posts (Band 2-6).

Their ambition is to ensure that all successful new staff demonstrate the best values and attitudes and are clear about what it means for patients to be the number one priority in their roles.

Values-based recruitment involves using the Trust's core values, which were developed through significant engagement with staff and the public, as a common set of standards to assess candidates. The core values are for staff to be:

- Caring.
- Compassionate.
- Respectful.
- Honest.
- Transparent.

The process includes both interviews and group assessments to test people's understanding of some of the real challenges facing staff.

Exercises consider real situations, including situations such as those at Winterbourne View, and assess the understanding that candidates have of their role in providing good care and in challenging poor practice.

The Trust is looking for candidates who understand that it is part of their job to challenge in the right way, and who understand the vulnerabilities that patients can experience.

Compassionate care is not, however, just about attitudes and individual development but is also about structures and processes. Organisations need to treat the development of a compassionate culture in the same way as they would any other initiative –planning for it, creating processes to support it and incorporating it into their daily practice. An example is given in Box 2 from a 2012 Edinburgh Napier University Leadership in Compassionate Care report.

Box 2: Organisational factors contributing to a compassionate culture[33]

The 2012 Edinburgh Napier University Leadership in Compassionate Care report identified the following eight organisational factors as being key to implementing a compassionate culture

1   Creation of dedicated 'spaces' to have caring conversations to share perspectives about care and discuss practice. This needs to happen at local and organisational levels.

2   Linking, aligning and integrating compassionate care activities to other organisational processes, targets, and quality initiatives.

3   Senior management support – e.g. local action groups led by senior staff and supported by Nurse Managers and Chief Nurses, focused on quality improvement and taking forward compassionate action programmes. Management being proactive in doing daily/weekly 'walk-abouts' in the ward area to ask the outcomes of initiatives such as relative rounds. Progress updates via the Senior Management Team meetings.

4   Reflective forums such as action learning. These greatly enhance staff ability to learn from practice, take forward change and develop transformational leadership skills.

5   Committed senior staff who are actively involved in supporting the development of compassionate care and who have the authority to support changes to practice.

6   Leadership programmes – in particular the opportunity these bring to increase and maintain capacity for leadership in compassionate care across the organisation.

7   Patients and families involved in shaping service development and pre-registration curriculum delivery.

8   Treating staff with dignity and respect as well as patients and families.

Recommendation

Mental health is facing some very difficult problems in recruitment, image and morale – although there are enormous variations between Trusts. Part of the problem is that mental health does not yet have parity with physical health and has suffered disproportionately from financial cuts in recent years as well be discussed in Chapter 8. There are, however, many things that Boards and leaders of Trust can do to improve the situation.

The Commission recommends that:

11 All mental health organisations promote leadership development and an open and compassionate culture with particular reference to better ward management, values-based recruitment, and staff training and development.

This will involve providers, with the support of commissioners, working to improve the skills and status of people working in inpatient care specifically through:

- A focus on developing ward managers and other inpatient staff.

- Running programmes to develop skills in quality improvement, working with people from other backgrounds and cultures, and working in partnerships with other organisations.

- Introducing values-based recruitment where this is not already in place.

- Reviewing career pathways to ensure a good supply of high quality ward managers and other inpatient staff.

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08

Finance and resources

Summary

This chapter describes current and planned expenditure on mental health and shows how the mental health sector has experienced greater pressures than the physical health sector. It describes some of the perverse incentives in the system and discusses quality improvement and waste.

The Chapter argues that a combination of increased funding, re-investment of savings and action by commissioners and providers is needed to improve services.

It recommends that greater financial transparency, removal of perverse incentives and the reduction of waste is coupled with investment in the priority areas identified here – acute care capacity, housing, information systems and staff – and guarantees about financial parity with physical health.

Expenditure on mental health

The difficulties in finding good information the mental health sector noted elsewhere apply equally to financial information – and a great deal of the information the Commission wanted was simply unavailable. Whilst gross figures for total expenditure on mental health are available, spend on acute adult mental health as opposed to other elements has not been collected nationally since 2011/12.

There is no way – other than through the uncertain route of Freedom of Information requests – to dig deeper and analyse expenditure in terms of particular elements of service such as inpatient services or Crisis Resolution and Home Treatment (CRHT) teams. While organisations such as NHS Benchmarking provide reliable analysis on the data that is available, there are many gaps which make benchmarking between Trusts or trend analysis extremely difficult. This sort of information is needed for operational reasons at the local level as well as for national level policymaking and accountability.

The Commission understood that the NHS England Mental Health Taskforce was undertaking a major analysis of mental health funding and expenditure and therefore decided not to duplicate this. Nevertheless, the Commission noted three major points:

1   While overall spend on mental health has increased recently, demand and activity has increased at a faster pace and some new commitments have been made.

2   Mental health Trusts have experienced greater cuts in recent years than Trusts providing physical health services.

3   There is enormous unexplained variation both in spend by commissioners and in Trusts' costs.

This Commission has only been concerned with acute adult psychiatric care, nevertheless, it has shown how the whole mental health system is connected and that every part is dependent on the others. In particular, it notes that one of the biggest risks for the future lies in local government funding of social services, housing and other vital services which psychiatric patients and their carers depend on.

The first two of these points – faster growth in activity than resources and recent reductions in NHS expenditure – have led to the attrition in services and increased pressure on staff described earlier in this report. The third point reveals once again the importance of adequate data and consistent definition and practice across the whole sector.

Taking these points in turn, the total NHS England mental health spend in 2013/14 was £11.362 billion and is predicted to be £11.664 billion for 2014/15.[1] Most NHS spend on mental health services is commissioned by Clinical Commissioning Groups (CCGs). In 2013/14 CCGs spent £7.8 billion on mental health and in 2014/15 they spent £8.3 billion on mental health services. They are predicted to spend £8.6 billion in 2015/16. These figures exclude specialised health services, mental health primary care services and other services directly commissioned by NHS England but for which figures are not available.[2]

Turning to earlier years, annual accounts show that between 2012/13 and 2013/14 44.8% of mental health Trusts experienced a reduction in income – and 38.6% did so in the following year. This is in marked contrast to the acute sector, where more than 85% of Trusts saw their income increase over the same period.[3] This picture of declining resources is confirmed by Freedom of Information requests conducted in 2015 which found that there had been a real terms decrease of 8.25% in the funding allocated to mental health Trusts between 2010/11 and 2014/15. CRHTs had seen an 8% cut in funding despite an 18% rise in average monthly referrals, while Community Mental Health Teams (CMHTs) had seen a 19% rise in referrals despite a slight fall in real terms funding.[4]

The discussion and analysis provided in earlier chapters, and summarised in Figure 2 in Chapter 1, show how activity has increased in recent years despite these financial pressures. Taken together with the financial reductions this shows how mental health has been put under increasing pressure in recent years – with some evidence that it has faced greater pressure than the physical health sector.

Figure 1: Comparative spend by mental health NHS Trusts (£)								
Property name	**Lowest value**	**Highest value**	**Lower quartile**	**Upper quartile**	**Mean**	**Median**	**Mean**	**Median**
Adult Acute: total cost per admission (inc. corporate overheads)	3,840	18,291	9,240	15,013	11,569	11,506	11,170	11,956
Cost per Adult Acute bed per annum	54,051	180,251	110,939	140,347	123,474	129,141	117,316	122,588
Total cost of community services per 100,000 registered population	3,905,012	10,351,322	4,285,381	6,411,121	5,582,741	5,062,194	5,055,571	
Total cost of community services per 100,000 weighted population	2,448,521	9,053,242	3,664,132	5,620,943	4,710,009	4,031,677	4,976,315	
Total cost of adult acute beds per 100,000 registered population	1,066,763	5,125,326	1,994,321	2,782,969	2,501,789	2,459,123		
Total cost of adult acute beds per 100,000 weighted population	863,467	4,109,421	1,972,651	2,969,550	2,400,822	2,252,217		

Data Source: Information received by the Commission from NHS Benchmarking

There is enormous unexplained variation in mental health spend by CCGs – with a roughly threefold difference in the amount spent on mental health.[5] The differences are even wider for Trust expenditure. Figure 1 shows the amounts spent by Trusts on services and elements of services in 2104/15 in figures gathered by NHS Benchmarking.

Some part of these variations will be due to difference in geography and population and to the different policies and investment decisions of different organisations. However, differences of this scale point to problems with the quality of data and consistency of definitions and accounting practice that need to be rectified so that commissioners and Trusts alike can can undertake their responsibilities effectively.

Looking forward, the Chancellor promised an additional £600 million for mental health services in the 2015 Spending Review.[6] This follows the announcement of £1.25 billion for child and adolescent services in March 2015.[7] Moreover, in the planning requirements for 2015/16, commissioners were required to invest additionally in mental health in line with their increase in allocation. The total planned additional spend is £376 million, an increase of 4.5%.[8] Government has further agreed to work with the Mental Health Taskforce on transformative plans, including improving the coverage of crisis care.[9] The Prime Minister has subsequently confirmed that £400 million will be spent on strengthening CRHTs.[10]

There is undoubtedly some improvement being made – and the Commission particularly welcomes investment in CRHTs. Nevertheless, the outlook for mental health is for continuing financial pressure and increasing numbers of people using services[11] – both of which mean that the recommendations in this report about improving quality and the way the system works are of vital importance for the future.

Perverse incentives in the system

There are two sets of perverse incentives in the system, one primarily affecting commissioners and the other providers, which complicate matters and make rational decision-making more difficult.

The discussion of commissioning in Chapter 3 described a situation where different groups commission different services in different ways. This is inefficient in the various ways described earlier for example, leading to people staying in one service for longer than necessary. These inefficiencies also have financial consequences. There are at least four main areas where there are perverse incentives leading to cost shifting and budget protection that are not in patients' best interests:

1   A Trust may need to keep someone in a ward at a very high cost simply because the budget for an alternative cheaper placement is controlled by another body – equally, a Trust may refuse to take a patient into a service who is currently being looked after elsewhere at another body's expense.

2   Private sector placements are often done on a spot purchase basis – without any saving that may come from pre-negotiated contracts – because private sector organisations are not normally engaged in planning processes.

3   Trusts often spend large sums on out of area placements because they do not have the funding to develop new services themselves – which might be strengthened CRHTs or more beds – even though these would be better for patients and cheaper in the long run.

4   Payment systems are provider specific which means that patients who may need services from more than one source may only get part of the care they need.

The perverse incentive affecting providers was mentioned in Chapter 2 and illustrated with a figure which showed that the costs of one acute bed equalled 44 patients on a CMHT caseload or 18 on an Early Intervention in Psychosis (EIP) team caseload.[12] As noted, a Trust might be tempted for financial reasons to close beds before there was adequate alternative provision available. It was argued in Chapter 2 that *service capacity assessment and improvement programmes* need to have risk assessment built in so that well-informed decisions could be made.

A recent King's Fund report has raised related concerns about the huge amount of strain that the mental healthcare sector is under, and the implications of this for patient care. They argue that financial pressures (and, in effect, this perverse incentive) have led to Trusts *"embarking on large-scale transformation programmes aimed at shifting demand away from acute services towards recovery-based care and self-management. This has seen a move away from evidence-based services in favour of care pathways and models of care for which the evidence is often limited"* for example by amalgamating functionalised community teams into generic community teams. There has also been little formal evaluation of the impact of these changes, with the King's Fund calling them a *"leap in the dark".*[13]

Financial pressures should, of course, lead people to innovate and look for new solutions – it is good that they do – and many major advances come from precisely this source. However, such innovations need to be tested through the sort of quality improvement process described in Chapter 4 and risks assessed before they are implemented at scale.

These problems demonstrate the importance of implementing some of the Commission's earlier recommendations about better coordination across the whole system, the need for commissioning to take account of all services and, wherever possible, to develop lead commissioner and lead provider roles. It is interesting to note that many of the examples of innovation and good practice throughout this report involve providers working around the rules to find ways of doing things – by, for example, Trusts paying for patients to be in rented accommodation, even though it is not their responsibility to do so.

These problems point to the need for improvements in contractual and funding arrangements in an effort to remove perverse incentives and improve the way the system works. In particular further attention needs to be given to Payment by Results.

Payment by Results

Payment by Results (PbR) was introduced in the NHS in 2003/04 to improve the fairness and transparency of payments and to stimulate provider activity and efficiency. PbR means that providers are paid for the number and type of patients treated, in accordance with a set of national rules and a national tariff for acute psychiatric services.

After a lengthy period of consultation 21 care clusters were mandated for mental health in 2012. The clusters are the currencies for most mental health services for working age adults and older adults. Patients have to be assessed and allocated to a cluster by their mental health provider, and this assessment must be regularly reviewed in line with the timing and protocols set out in the mental health clustering booklet. It also means that the clusters must form the basis of the contracting arrangements between commissioners and providers.[14] In 2013/14, CCGs and providers were required to agree a local price for each cluster. Currencies are also being developed for a wider range of mental health services including Improving Access to Psychological Therapies (IAPT).[15]

PbR in mental health is intended to support the transition from traditional block contracts to an activity and outcomes-based contracting mechanism. Its success relies on improved availability of data on activity and outcomes to support funding flows from commissioners to providers. However, PbR has proved difficult in mental health for several reasons including the following:

- People with mental health problems may also have physical health needs with attendant costs.

- They may also have social needs and their illness can impose costs on other sectors such as social services, education, employment and the criminal justice system which will not be covered by this system.[16]

- The clusters developed before, rather than out of, care pathways and the sample of services from which the clusters were derived did not include acute care, rehabilitation care or older adults services; the clusters only essentially and inadequately related to the CMHT element of the pathway.

Looking forward this system needs to develop so as 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.[17]

Improving quality and reducing waste

There is a need for more investment in mental health and for it be treated equitably with physical health. However, there is also a great deal that commissioners and providers can do themselves to make improvements. The earlier chapters have not only described the inefficiencies of the whole system but the opportunities for quality improvement. Much of quality improvement, contrary to conventional thinking, saves money by eliminating waste.

There is an enormous amount of waste in health care generally. Figure 1 illustrates what Professor Noriaki Kano, credited as the father of the Toyota Production System – which led to the development of LEAN in the West – called the 'seven wastes'. They will all be familiar to health practitioners – from unnecessary waiting to duplication and missing information to the one highlighted in Figure 2 which describes many situations we have all experienced – *"Unnecessary processes and operations traditionally accepted as necessary"*.

These wastes appear in all systems in different ways and lead to frustration for patients and health workers alike. This is a global problem: the World Health Organisation suggests that: *"Conservatively speaking, about 20–40% of resources spent on health are wasted, resources that could be redirected towards achieving universal coverage."*[18]

Improving quality will in most cases also improve costs. Eliminating these wastes is the biggest source of savings and efficiency improvement in health. Professor Noriaki Kano has identified three types of quality improvements:

- **Reducing defects**. Examples of health care defects include healthcare acquired infections, medication complications, delayed discharges, and long waiting times.

- **Reducing the cost of production, while maintaining or improving the experience of the customer**. Examples in health care include avoiding duplicative testing and assessment – and duplicated commissioning – reducing unnecessary treatments, eliminating administrative complexity and paperwork, having work done by different groups of staff or facilitated by technology. Eliminating out of area treatments is a prime example of this sort of quality improvement.

- **Adding a new feature or a new product or service**. Examples in health care are new community services, improved facilities, therapies and drugs.[19]

The first and second types save money whilst the third will often cost more. In other industries, improvements in the first two types are often relied on to fund the cost of the third. The many examples of innovation described in this report show organisations adopting precisely this approach. It underlies the whole Quality, Innovation, Productivity and Prevention (QIPP) programme in the NHS.

Earlier chapters have shown the enormous scope for quality improvement through the elimination of waste. For example:

- Ensuring that patients are being treated at the right level of care will mean that resources are not wasted.

- Engaging carers at admission will generally improve quality, reduce risk, help avoid some future problems and make the experience of treatment better.

- Discharging patients into suitable accommodation when they are ready will help counter institutionalisation and may accelerate rehabilitation and reduce the overall use of services.

- Eliminating out of area treatments should generally improve quality and reduce costs.

These processes will release money and it is important that this is re-invested in mental health both to improve services and to provide the incentive for local leaders to pursue cost-saving improvements.

Figure 2: The seven wastes

Processing
Unnecessary processes and operations traditionally accepted as necessary

Motion
- Unnecessary movement or movement that does not add value
- Movement that is done too quickly or slowly

Defects
- Waste related to costs for inspection of defects in materials and processes
- Customer complaints
- Repair

Time
- Waiting for people or services to be provided
- Time when your processes, people and machines are idle

Waste

Transportation
Conveying, transferring, picking up, setting down, piling up and otherwise moving unnecessary items

Overproduction
Producing what is unnecessary, when it is unnecessary, and in unnecessary amounts

Inventory
- Maintaining excessive amounts of parts, materials or information for any length of time
- Having more on hand than what is needed and used

Priority areas for new investment

The Commission has not attempted to cost the financial needs of the mental health system, noting that this is being undertaken by NHS England's Mental Health Taskforce. Most of the Commission's recommendations cost little if anything to implement and will save money as well as improve quality.

More generally, the Commission believes that there is enormous scope for improvement in mental health within current resources and that – in some cases at least – financial pressures will force people to look at how they are doing things and make improvements. There are examples of this all over the country. However, it also believes that there is a need for more funding to accelerate improvement and in particular in:

- Strengthening CRHTs.
- Developing information systems.
- Upgrading inpatient services with improved levels of activities, staffing and staff training, and better environments.
- Providing greater access to suitable housing where and when it is needed.

Recommendation

The mental health sector has suffered from a steady attrition in funding from both NHS and local government sources in recent years and has not been treated on a par with physical health.

The Commission welcomes the increased focus on mental health both nationally and globally. It agrees with the argument that increased investment in mental health adds value to individuals, their families and society as a whole.[19] It particularly welcomes the recently published *Delivering the Forward View: NHS planning guidance 2016/17–2020/21* guidance, which makes it clear that *'commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase.'* This is a positive step towards parity of esteem. The guidance also says that additional funding will be made available to CCGs from the new National Sustainability and Transformation Fund where they can demonstrate they have practical and strategic plans for improvement.[20]

Although these recent initiatives are extremely welcome, the litmus test for parity of funding for mental health will be if the same level of service is funded as would be expected for physical health. Patients accessing physical healthcare have benefited from maximum waiting time targets for many years, and both the previous Coalition Government and NHS England have set out an ambition for an equivalent, comprehensive suite of access and waiting time standards (many of which are directly relevant to acute adult care) to be introduced in mental health by 2020.[21,22] However, both acknowledged that this would require additional funding to be specifically allocated to implementing such standards by the current government. The current government committed in the 2015 Spending Review to spend an extra £10bn on the NHS by 2020,[23] and the Commission encourages them to confirm as a matter of urgency that funding will be available via this for the implementation of the anticipated comprehensive suite of access and waiting time standards for mental health.

Whilst the government needs to address these funding and resource issues, there is also much that local commissioners and providers need to do to improve quality and the whole way the system works. Moreover, as noted earlier, adequate local government funding is required to provide vital social services and housing.

The Commission recommends that:

12 Greater financial transparency, removal of perverse incentives and the reduction of waste is coupled with investment in the priority areas identified here – acute care capacity, housing, information systems and staff – and guarantees are made about financial parity with physical health.

This will involve:

- NHS England, providers and commissioners improving financial analysis and transparency of data so that the public has access to information about costs and investment.

- NHS England developing commissioning and payment systems to remove or reduce the effect of perverse incentives in the system.

- NHS England, commissioners and providers giving priority for new investment to strengthening CRHTs, developing information systems, upgrading inpatient services with improved levels of activity on wards, staffing, staff training, better environments and providing greater access to suitable housing where and when it is needed.

- NHS England and commissioners ensuring that savings from the reduction of out of area treatments and other initiatives are re-invested in mental health.

- NHS England and commissioners ensuring that mental health receives the same level of financial uplift and investment as physical health.

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09

Conclusions and recommendations

Conclusions

This report has painted a picture of an acute mental health system under pressure with difficulties in access to care compounded by – in some instances – poor quality of care, inadequate staffing and low morale. The whole system has suffered from a steady attrition in funding from both NHS and local government sources in recent years. Despite this, some Trusts have been able to make significant improvements in recent years and there is much good practice in the sector.

The Commission's recommendations taken together with the forthcoming report of the NHS England Mental Health Taskforce set out an agenda for making dramatic improvements. Central to all the Commission's recommendations is the idea that patients with mental health problems should have the same rapid access to high quality care as patients with physical health problems.

The new priority given to mental health in England and the fact that there are already many good examples of good services and good practices mean that there are reasons to be optimistic about significant improvement in the next few years. This can be achieved if government and organisations throughout the system have the sustained commitment and will to make it happen. Delivering these improvements will require great commitment and energy from many different people and organisations – both of which need to be sustained over time.

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 England 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 UN's development agenda for 2016-2030 – having not been included in their predecessor Millennium Development Goals which ran from 2000-2015. 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 bio-psycho-social-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 being more engaged in physical health. The current divide – and the bad consequences for the health of patients – was a matter of great concern to many people who provided evidence to the Commission.

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 health[3] – 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 England over the next decade and beyond.

Recommendations and implementation

The Commission makes 12 linked recommendations which if implemented in full will dramatically improve the situation. Almost all of these recommendations build on existing good practice somewhere within the NHS.

It is very important that commissioners and providers should not wait for the implementation of these recommendations to deal with the immediate issues that clinicians face of, too often, being unable to provide safe and appropriate care for patients. Short-term measures such as an increase in bed provision or the purchase of capacity from the private sector may be required whilst the longer-term measures set out in this report are developed and implemented.

This summary of recommendations identifies the key actions that need to be taken for successful implementation. The Commission proposes that the Royal College of Psychiatrists should review their implementation in October 2017.

The Commission recommends that:

1   **A new waiting time pledge is included in the NHS Constitution from October 2017 of a maximum four-hour wait for admission to an acute psychiatric ward for adults or acceptance for home-based treatment following assessment.**

    This will involve:

- NHS England and NHS Improvement establishing the definitions and arrangements needed for measurement and data collection and adding this pledge to planning and monitoring processes and performance announcements.

- Trusts and other providers working with their commissioners to establish local arrangements for data collection and local publication of results.

2   **The practice of sending acutely ill patients long distances for non-specialist treatment is phased out nationally by October 2017.**

    This will involve:

- NHS England and NHS Improvement introducing a target for halving current levels of out of area treatments for acute adult inpatient care by April 2017 and their total elimination by October 2017.

- NHS England and NHS Improvement holding both commissioners and providers to account for achieving this target.

- NHS England and NHS Improvement establishing a national reporting system for monitoring the number, nature and causes of out of area treatments by July 2016, publishing a complete national baseline picture by September 2016.

- Commissioners and providers working together with patients' and carers' groups locally to agree what constitutes an out of area transfer in their locality within the national framework and definitions provided by NHS England and NHS Improvement.

- The Care Quality Commission changing its inspection framework in response to both this and Recommendation 1 so that unacceptable distance travelled is measured along with unacceptable waiting times in judging whether a service is responsive to local needs.

3 Commissioners, providers and Strategic Clinical Networks in each area together undertake a *service capacity assessment and improvement programme* to ensure that they have an appropriate number of beds as well as sufficient resources in their Crisis Resolution and Home Treatment teams to meet the need for rapid access to high quality care by October 2017.

This will involve:

- Trusts, with the support of their commissioners, using a systematic method, such as the *service capacity assessment and improvement programme* described in this report, to ensure that by October 2017 the acute care service can meet capacity demands in their area.

- Mental health Strategic Clinical Networks establishing a process by October 2016 for the sharing of learning and good practice between organisations in their area.

- Trusts and commissioners providing a quarterly report beginning from October 2016 for Commissioning and Trust Boards and wider public dissemination – and ensuring that remedial action is taken to improve progress where necessary.

4 Service providers, commissioners and Health and Wellbeing Boards work together to improve the way the mental health system works locally – sharing information, simplifying structures where appropriate, and finding innovative ways to share resources and deliver services.

This will involve:

- Joining up processes and systems wherever possible. This will build on existing shared mechanisms such as care plans and care pathways but should also involve better real time sharing of information and the engagement of all relevant bodies, including the private sector, in planning and communications.

- Mapping the whole system and analysing patient flows so as to identify how well the current system is being used and whether patients are being cared for in the right services.

- Simplifying the system wherever possible. This will involve reducing boundaries and hand-offs between organisations and services perhaps through using lead commissioners, lead providers and bringing together different types of services.

- NHS England working with commissioners to improve the whole way the commissioning process works.

5 There is better access to a mix of types of housing – and greater flexibility in its use – to provide for short-term use in crises, reduce delayed discharges from inpatient services and offer long-term accommodation.

This will involve:

- Commissioners, Local Authorities and housing providers working together to ensure that there is an adequate supply of appropriate housing to enable patients to be discharged from hospital when they no longer need inpatient treatment.

- This will require the Local Authority and CCG(s) to establish a decision-making processes that can occur within 24 hours of a referral being made and also to provide sufficient:
  - Crisis housing
  - Short-term temporary accommodation for patients ready for discharge
  - Supported accommodation for patients with mental health problems
  - Accommodation for patients with complex problems who may be difficult to house.

6 A single set of easy to understand and measurable quality standards is developed nationally with the involvement of patients and carers and widely promoted and communicated.

This will involve the Royal College of Psychiatrists together with NHS England, NHS Improvement, the Care Quality Commission and NHS Providers reviewing the current range of published quality standards in order to:

- Produce a short user-friendly statement of measurable best-practice standards agreed by all the relevant bodies.

- Promote this statement amongst staff, patients and carers providing opportunities for it be understood and, where appropriate, tailored to local services.

- Seek to align this statement and the with the Mental Health Minimum Data Set so that performance against the standards can be monitored and reported on through the existing arrangements. This recommendations should be addressed alongside Recommendation 10 in Chapter 6.

7 The growing awareness and use of quality improvement methodologies in mental health is nurtured and accelerated.

This will involve:

- Providers adopting a systematic approach to quality improvement and setting up training and development programmes for their staff.

- Providers and commissioners working with Strategic Clinical Networks to share good practice.

- Providers and commissioners nationally considering with NHS England what arrangements can be put in place to enable the active sharing and implementation of good practice nationally.

- The Royal College of Psychiatrists (RCPsych) and the Royal College of Nursing (RCN) actively supporting the development of quality improvement knowledge and skills amongst their Fellows, Members and Trainees and the RCPsych considering how its College Centre for Quality Improvement can play an even more active role in this.

8 Patients and carers are enabled to play an even greater role in their own care as well as in service design, provision, monitoring and governance.

This will involve providers, with support from commissioners and other partners:

- Working with patients and carers to further develop their involvement in all aspects of the organisation.

- Ensuring that patients and carers involved in these activities receive the training, development and support they need to do so.

- Evaluating programmes and sharing good practice and learning both within their organisation and more widely.

9 A *Patients and Carers Race Equality Standard* is piloted in mental health alongside other efforts to improve the experience of care for people from Black and Minority Ethnic communities.

This will involve NHS England and NHS Improvement working with patients and carers groups, NHS Providers, the NHS Confederation Mental Health Network and the Royal Colleges of Psychiatrists and Nursing to:

- Identify a clear and measurable set of Race Equality Standards for acute mental health services by October 2016 and pilot them in a selection of Trusts from April 2017.

- Set up monitoring and public reporting processes for all Trusts from April 2018.

10 The collection, quality and use of data is radically improved so it can be used to improve services and efficiency, ensure evidence-based care is delivered and improve accountability.

This will involve:

• The Department of Health and NHS England bringing nationally available information together into a single resource adding to it as necessary to support operational management locally.

• The Department of Health, with NHS England and NHS Improvement leading a review of the Mental Health Minimum Data Set to ensure its fitness for purpose for monitoring and evaluating acute care pathways and converting this into a publicly available set of performance measures that enable local and national analysis of the state of acute mental healthcare and the outcomes being achieved. This work must include a review of the current Delayed Transfer of Care definition and data collection system which are not fit for purpose.

• Commissioners and providers collaborating to develop local operational systems which will allow for sharing of critical information and help the whole system work more effectively.

• Providers developing their internal systems to provide open real time information to their staff and, in the longer term, ensuring that evidence as well as care pathways and protocols are available to all relevant staff where and when they need them.

11 All mental health organisations promote leadership development and an open and compassionate culture with particular reference to better ward management, values-based recruitment, and staff training and development.

This will involve providers, with the support of commissioners, working to improve the skills and status of people working in inpatient care specifically through:

• A focus on developing ward managers and other inpatient staff.

• Running programmes to develop skills in quality improvement, working with people from other backgrounds and cultures, and working in partnerships with other organisations.

• Introducing values-based recruitment where this is not already in place.

• Reviewing career pathways to ensure a good supply of high quality ward managers and other inpatient staff.

12 Greater financial transparency, removal of perverse incentives and the reduction of waste is coupled with investment in the priority areas identified here – acute care capacity, housing, information systems and staff – and that guarantees are made about financial parity with physical health.

This will involve:

- NHS England, providers and commissioners improving financial analysis and transparency of data so that the public has access to information about costs and investment.

- NHS England developing commissioning and payment systems to remove or reduce the effect of perverse incentives in the system.

- NHS England, commissioners and providers giving priority for new investment to strengthening CRHTs, developing information systems, upgrading inpatient services with improved levels of activity on wards, staffing, staff training, better environments and providing greater access to suitable housing where and when it is needed.

- NHS England and commissioners ensuring that savings from the reduction of out of area treatments and other initiatives are re-invested in mental health.

- NHS England and commissioners ensuring that mental health receives the same level of financial uplift and investment as physical health.

References

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2   United Nations (2015). UN General Assembly Resolution 70/1: Transforming our World: the 2030 Agenda for Sustainable Development. Available at: 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. *BMJ*, 351:h6654

4   Frenk, J., Chen, L., Bhutta, ZA. *et al*. (2010). Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet*, 376, pp.1923-58.

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 Havering 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 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, the Division Chair in Northern Ireland, 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 from people with lived or clinical experience, as well as submissions from organisations such as the King's Fund, the Royal College of Nursing, Mind, Rethink, and SANE.

5 Survey of Acute Psychiatric Wards

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

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 and the consultation on its Interim Report. The Commission is also grateful to the medical directors and psychiatrists who supported the Commission's survey on acute psychiatric wards.

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

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.

- South London and Maudsley NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- Belfast Health and Social Care Trust
- Northern Health and Social Care Trust
- East London NHS Foundation Trust
- North East London NHS Foundation Trust
- Southern Health NHS Foundation 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:

- Dr Paul Rowlands, Dr Lenny Cornwall and Lauren Wright on behalf of the College's General Adult Faculty

- The College's Division Chairs and Division Offices, in particular Dr Diana Day-Cody, Nora McNairney and Thomas McKeever at the College's office in Northern Ireland

- Mark Beavon and the RCPsych AIMS network

- Dr Fiona Mason

- The College's Communications Department, in particular Kathryn Stillman, Kathy Oxtoby and Claire Mcloughlin

- The College's Policy Unit, in particular Greg Smith, Krista Nicholson, Chris Fitch and Lucy Thorpe

Additional evidence and support

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

Organisations

- NHS Providers
- Independent Mental Health Services Alliance (IMHSA)
- Mental Health Providers Forum (MHPF)
- SOLACE
- 5 Boroughs Partnership NHS Foundation Trust
- Belfast Health and Social Care Trust
- Camden and Islington NHS Foundation Trust
- Central and North West London NHS Foundation Trust
- Coventry and Warwickshire Partnership NHS Trust
- Devon Partnership NHS Trust
- Dorset HealthCare University NHS Foundation Trust
- East London NHS Foundation Trust
- Greater Manchester West Mental Health NHS Foundation Trust
- Lancashire Care NHS Foundation Trust
- North East London NHS Foundation Trust
- North Essex Partnership University NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Oxford Health NHS Foundation Trust
- Southern Health NHS Foundation Trust
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust

Individuals

- Dr Martin Baggaley
- Dr Jay Banerjee
- Annette Bartley
- Stephen Bergin
- Professor Len Bowers
- Dr Alison Brabban
- Dr Ruth Briel
- John Brouder
- Dr Paul Brown
- Dr Wendy Brown
- Dr Neta Chada
- Dr Kevin Cleary
- Megan Cleaver
- Dr Lenny Cornwall
- Professor Mike Crawford
- Pedro Delgado
- Julie Dent
- Dr Robert Dolan
- Grahame Ellis
- Dr Navina Evans
- Sharon Gilfoyle
- Alice Glover
- Marion Janner
- Dr Sri Kalidindi
- Molly Kane
- Sarah Khan
- Professor Helen Killaspy
- Dr Gerry Lynch
- Chris Mathews
- Dr Deirdre McGlennon

- Dr Ian McMaster
- Barney McNeany
- Dr Phil Moore
- Clare Morris
- Rodney Morton
- Aidan Murray
- Dr Maria O'Kane
- Dr Tony O'Neill
- Lesley Osbaldestin
- Dr Matthew Patrick
- Katrina Percy
- Dr Nial Quigley
- Dr Jonathan Richardson
- Adrianne Roberts
- Kathy Roberts
- Dr Diana Rose
- Dr Amar Shah
- Dr Geoff Shepherd
- Dr Emma Stanton
- Dr Lesley Stevens
- Elaine Swift
- Karen Turner
- Andrew Van Doorn
- Dr Dimple Vyas
- Melanie Walker
- Hazel Watson
- Caroline Wild
- Faye Wilson
- Dr Adrian Worrall

The Commission is grateful to the following consultants who completed research on behalf of the Commission:

- Contact Consulting
- Dr Jan Wallcraft
- Mental Health Strategies
- Tony Ryan Associates

Julie Cullen from AQuA kindly peer reviewed a draft version of the report.

The Commission is also very grateful to NHS Benchmarking for allowing the Commission to access some of the data collected by their mental health Benchmarking Club.

The Commission would also like to thank RaffCreative for completing design work for the Commission.

Appendix 3:

The Workforce Race Equality Standard[1]

The Workforce Race Equality Standard (WRES) requires organisations employing almost all of the 1.4 million NHS workforce to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of Black and Minority Ethnic (BME) Board representation. All providers, (excluding "small providers"), have been required to implement the WRES since April 2015 as part of the 2015/16 NHS standard contract.

The WRES indicators are outlined in Box 1.

Box 1: The WRES Indicators

Workforce indicators

1   Percentage of BME staff in bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce.

2   Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts.

3   Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

4   Relative likelihood of BME staff accessing non mandatory training and CPD as compared to white staff.

National NHS Staff Survey findings

5   Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

6   Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

7   Percentage believing that Trust provides equal opportunities for career progression or promotion.

8   In the last 12 months have you personally experienced discrimination at work [from a] Manager/team leader or other colleagues.

NHS Board leadership

9   Boards are expected to be broadly representative of the population they serve.

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1   NHS England (2015). *The NHS Workforce Race Equality Standard – the defined metrics*. Available from: www.england.nhs.uk/wp-content/uploads/2015/02/wres-metrics-feb-2015.pdf [Accessed 19 January 2016].

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about the Commission
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www.caapc.info