

The pathway to recovery

A review of NHS acute inpatient mental health services

Summary document



Summary

The importance of acute inpatient mental health services

A key aim of mental health care in England in recent years has been on supporting people to live more independent lives through better care and treatment in the community.

The emphasis placed on strengthening community services has meant that acute inpatient services have not always received the attention needed to ensure that service users are fully involved in planning their own care, and that care is safe and effective.

A number of reports have highlighted concerns about the quality of provision of acute inpatient services, with clear evidence of unmet needs. This has also led to public concern about the safety of these services. In response, the Government set out clear policy and objectives, along with capital investment, to ensure that appropriate acute services are available as part of the pathway of care. A range of national initiatives has been launched to support and coordinate improvement in the quality of these services.

While this presented a timely opportunity to assess the extent to which the policy objectives have been implemented, it is also important that the findings are considered in the context of current policy objectives – personalised care, improved clinical pathways, and continued reduction in the barriers and stigma that people with mental health problems often face in our society.

The focus of the review

Our service review has assessed the quality and safety of care provided by NHS acute inpatient mental health wards and psychiatric intensive

care units (PICUs) in England. The overall focus of the review is on assessing whether admissions to inpatient mental health services are appropriate, purposeful, therapeutic and safe. The four key criteria against which we assessed performance were:

1. There is an effective care pathway that ensures admission to hospital is appropriate and that discharge from hospital is timely.
2. Inpatient services focus on the needs of the individual and provide care that is personalised and promotes recovery and inclusion.
3. Service users and carers are involved in care planning, in how the ward is run and in operational and strategic planning, evaluation and development.
4. The ward has systems, processes and facilities in place to ensure the safety of service users, staff and visitors.

We assessed all of the 69 NHS trusts that provided mental health acute inpatient services during 2006/2007. These trusts registered 554 acute mental health wards within the scope of the review, providing a total of 9,885 beds. We used a combination of national and bespoke data as part of a rigorous assessment process, and our findings fed into our annual health check of trusts' performance.

We gave trusts one of the following scores for the review: "excellent", "good", "fair" or "weak". The overall score was based on the aggregation of results from 58 indicators. All indicators were equally weighted, with the exception of one indicator on whether service users' views were recorded on their most recent care plan. This carried more weight than the others.

Overall results

The general breakdown of the overall results showed that:

- We scored most trusts as fair (30 trusts, 43%), followed by good (20 trusts, 29%).
- Almost as many trusts were scored as excellent (8 trusts, 12%) as weak (11 trusts, 16%).
- The proportion of trusts in this review that were scored excellent was the same as that in our previous review of community mental health services, but a higher proportion were scored weak for the quality of their inpatient services.

There were differences in the distribution of the overall scores by type of trust. The trusts that had become foundation trusts at the time of the review performed better than other types of trust.

The best performers were more likely to be smaller trusts in terms of the number of wards and beds. For instance, the trusts that were scored excellent provided 843 (9%) of the total beds, while the trusts that were scored weak provided 2,249 beds (23%). The trusts that were scored weak were more likely to be larger and serving an urban, more deprived population.

It was not possible to test these findings to see if they were significantly different, because the number of trusts in the review was relatively small. However, these results do suggest that the larger the trust, the greater the challenge in achieving consistent standards across all wards. It is therefore important that commissioning of acute care services takes account of the particular challenges faced by those larger trusts serving an urban, more deprived population, to ensure delivery of a quality service.

On the four key criteria against which we assessed performance (acute care pathway, whole person care, involvement of service users and carers, and safety) our findings were:

- No trust was scored excellent on all four of the key criteria, suggesting there is room for improvement for all service providers.
- Almost two-fifths of trusts (39%) were scored weak on involving service users and carers – this was the area with the highest proportion of weak scores.
- Around one in every nine trusts was scored weak on the whole person care and safety criteria.
- No trust was scored excellent for the effectiveness of the acute care pathway, although fewer trusts were scored weak here compared with the other three criteria.

Key conclusions

Our review suggests that the renewed policy focus on acute care services, supported by a range of national initiatives, has started to facilitate progress in some areas.

The trusts that were scored excellent on this assessment demonstrate that personalised, safe and good quality acute care is both achievable and is being achieved.

However, there were very wide variations between trust performance and, in some places, marked differences between wards within trusts in relation to the quality of acute inpatient services provided. All trusts need to take action to address aspects of the review where we scored them as weak. It is therefore important that the momentum that has been generated to drive up quality is sustained and built upon.

We advocate an integrated approach to service development that ensures improvement to acute care services is coordinated with the development and delivery of other policy objectives, including Delivering Race Equality, Improving Access to Psychological Therapies, Refocusing the Care Programme Approach and the implementation of the amended Mental Health Act and policies for working with people with a dual diagnosis.

Positive findings

It is important to celebrate some of the successes that have been identified as encouragement to services to strive for further improvement.

In particular, we recognise local and national efforts that have resulted in positive outcomes in certain aspects of service:

- Good levels of access to specialist advice and support for certain groups, such as young people and older people.
- Health promotion activities – on diet and healthy eating, physical activity and smoking cessation – being available in the majority of acute wards.
- An increase in the proportion of mental health staff trained in diversity issues (although there is still further to go).
- The vast majority of service users receiving medication within British National Formulary guidelines during their first week of admission.
- Regular community meetings being held on the majority of wards, getting feedback from service users on the day-to-day running of the ward.
- Improvements in the quality of coding of data on the ethnicity of service users.
- A national average bed occupancy rate of 87%, which is close to the national recommended rate of 85%. Although there were marked local and regional variations, this suggests that many trusts were managing their acute inpatient beds effectively, with a view to ensuring patient safety.
- Ward managers reporting good levels of access to supervision for clinical staff on wards, and attention being given to developing leadership.
- The majority of acute care forums developing an action plan and reviewing it within the last year.
- Well-established access to independent advocacy and other engagement initiatives, such as patient advice and liaison services.
- A good range of audits having been carried out at ward level, on acute care issues.

What makes the difference?

We held a seminar with those trusts that had performed well on the assessment, to ask them what they thought made a difference in delivering high quality acute care services. Based on this work, and on the lessons we learned from follow-up visits to trusts that had been scored weak, we identified the following key factors:

- Priority given to modernising acute inpatient services within wider service development programmes and strategic plans and partnerships.
- Role and status of acute care forums – the local groups responsible for coordinating the

planning and development of acute care services.

- Organisational culture and readiness to embrace change.
- Effectiveness of wider systems and practices, including integration with other elements of mental health services, care coordination, multidisciplinary team working, communication and audit systems.
- Skills, competence and attitude of front line staff.
- Quality of, and support for, the workforce, particularly leadership, staff supervision, training and development.
- Involvement and engagement of service users and carers in development processes.
- Quality and sophistication of commissioning of acute care services.

Key priorities for improvement

Based on our findings, we have identified four key priority areas where improvements are needed to achieve better outcomes for services users and their carers.

Priority area 1: Putting a greater focus on the individual and care that is personalised

There were some positive results in relation to involving service users and carers in operational and strategic developments. However, our review indicates that there is still far more that services could do to involve service users in planning their own care.

The degree of variation in recording the views of service users on their care plan is unacceptable. Fifty per cent of care plans sampled did not record the service user's views. Overall, 55% of trusts were scored weak for this indicator. This is

an urgent issue that needs to be addressed in providing personalised care. We also found that 16% of care records indicated that service users had not had a one-to-one session with nursing staff on any day during their first week in hospital.

Staff should consider how practices can be adapted to involve and engage service users as much as possible, however unwell the person may be. Involvement should be based on a human rights approach, so that services are focused around the needs of service users rather than those of the services.

Approaches to involving carers need to be developed further. Nearly a third of care records (30%) did not record whether or not the service user had a carer. Only 32% of front line staff had been trained in supporting carers and families, and only two fifths of wards (40%) had a dedicated member of staff responsible for leading on carer issues. One in five wards (21%) did not have an information pack for carers containing any of the information we asked about, and we identified that information for both service users and carers could be made more accessible.

Our findings also suggest that there is scope for improvement in meeting the needs of people with diverse needs, especially people from black and minority ethnic groups. We have particular concerns that the views of people from black and minority ethnic groups were recorded less often on their care plans, and that a higher proportion did not have a one-to-one session during their first week of admission. This suggests that services should do more to engage service users from black and minority ethnic groups.

Going into hospital can result in people losing their jobs, homelessness, financial problems, social isolation and being distanced from everyday life, so it is important that

assessments include consideration of social issues.

Fifty-nine per cent of care records sampled showed that assessments included all of the following: employment/education status, accommodation status and needs, and caring responsibilities. However, 15% of care records had one or none of the assessments recorded.

We also identified that much more could be done to help people in hospital to maintain contact with their life outside hospital, and to bring in community organisations to facilitate groups and activities. Such inreach into acute wards and outreach from these wards into the community are important aspects of promoting social inclusion.

Commissioners and providers of mental health services need to take action to ensure that care and treatment is individualised and personalised, and responsive to local needs, by:

- Ensuring that all service users are effectively involved and engaged, and their views made explicit within individual care planning processes.
- Developing approaches to involving carers.
- Ensuring that service users and carers are better informed and information is more accessible.
- Paying greater attention to identifying and meeting the needs of people from black and minority ethnic groups.
- Promoting social inclusion, both within acute care settings and through strengthening links with the community, to help people keep in touch with their lives.

Priority area 2: Ensuring the safety of service users, staff and visitors

Safety is an extremely important issue for acute

inpatient services. It is reasonable to expect that, when someone is admitted to hospital, they feel safe. Equally, it is important that staff and visitors feel safe, and the evidence from this review – and the *2006/2007 National Audit of Violence* in mental health settings – highlights the continuing high level of violence experienced on some mental health inpatient wards.

The *2006/2007 National Audit of Violence* found that 43% of service users on acute wards for adults of working age had felt upset or distressed, 31% had been threatened or made to feel unsafe, and 15% reported being physically assaulted. Nationally, on average 11% of all service users were assaulted in 2006 according to their care records. Our review found that one in six trusts were significantly above this average. This is simply not acceptable in a 21st century service and would not be tolerated in other walks of life.

If we are to address seriously the levels of disturbance, violence and aggression on inpatient mental health wards, it is important that the findings of this review are used constructively to tackle the causes of violence.

A positive therapeutic environment where staff engage service users on an individual basis, and involve them in activities to support their recovery, is therefore essential. Although we found that the range of activities on offer was reasonable on most wards, the provision of activities during the evenings and at weekends on some is not good enough: 8% of wards delivered none of the activities we asked about.

Staff need to have the appropriate skills – supported by good role models, awareness of different models of recovery, and effective training and supervision – to identify the signs and causes of aggressive and violent behaviour and to intervene to prevent and manage incidents. This needs to be underpinned by

strong clinical leadership and commitment from senior managers, as well as effective risk assessment practice.

The NHS Litigation Authority's risk management standards provide an overall assessment of a trust's risk management systems. Based on the 2006/2007 final risk management assessment levels, only 19% of mental health trusts had achieved the clinical negligence scheme for trusts level that indicates that risk management systems and processes have been implemented in practice.

We also identified that developing practice in promoting sexual safety and sexual health, and in implementing strategies to reduce the likelihood of patients going missing, were also key areas for improvement. Assessment of the risk of sexual vulnerability was the least likely of the risk assessments we asked about to be completed, but with wide variation between trusts (from 4% to 100% of the care records audited). Nearly a third of trusts (30%) said that none of their ward-based nursing staff had received training in sexual safety awareness over a two-year period.

Over a six-month period, detained patients were away from the ward on unauthorised leave on 2,745 occasions. Although the frequency with which detained patients were absent without leave was relatively high, this was generally for brief periods (two to three days at a time) and the rate varied considerably between trusts, with just 6% having a significantly higher rate of service users going absent without authorised leave compared with the rest.

Commissioners and providers of mental health services need to take action to ensure the safety of service users, staff and visitors. They should focus on:

- Taking steps to minimise violence and aggression, using approaches that have been proven to work elsewhere.
- Promoting a more positive therapeutic environment and better engagement with service users.
- Promoting sexual safety and sexual health.
- Ensuring that risk management systems are implemented in practice.
- Looking at ways to minimise the likelihood of patients going missing, using national guidance and best practice approaches.

Priority area 3: Providing appropriate and safe interventions

Service users should be able to expect that the treatment they receive in hospital is appropriate to their needs and is safe and therapeutic. Our findings suggest that the assessment and recording process could be more systematic to ensure that relevant interventions and treatments are offered. Assessments and interventions should address the range of people's needs, including those whose needs are complex. On average, 76% of care records contained a valid diagnostic code, but at worst this was as low as 8% in one trust.

Just over 50% of service users had their mental capacity to consent to treatment assessed within the first seven days of admission. Only 56% of care records included a physical health examination, lifestyle assessment and haematological and biochemical screening checks, suggesting that the range of checks could be more comprehensive. Six per cent of wards offered no basic talking therapies. Only 27% of wards had 'hearing voices' groups on offer and psychosocial family interventions were available on less than half of all wards (46%). Around one in every 10 wards (11%) had

no occupational therapy available.

Despite the high levels of co-morbid mental health and substance misuse problems, only 26% of clinical staff reported having had training from their trust at any time in how to ask service users about their use of alcohol or drugs (including illegal drugs) and only 22% reported having had training in how to handle patients who are drunk or under the influence of drugs.

Commissioners and providers of mental health services need to take action to ensure that interventions provided are appropriate and safe. They should focus on:

- Improving the quality of coding of diagnoses.
- Making routine the assessment and recording of mental capacity to consent from the start of an inpatient admission.
- Ensuring that the range of physical health checks is more comprehensive.
- Improving the range of available therapies and interventions.
- Developing expertise in working with people with a dual diagnosis.

Priority area 4: Increasing the effectiveness of the acute care pathway

It is important that people are only admitted to hospital when it is the most appropriate course of action, and that they have access to alternatives that may prevent admission. If admission is needed, people should remain in hospital no longer than is necessary and be supported to make the transition back home. Our findings suggest that more needs to be done to improve support to people in a crisis in the community, and to enable people to move out of acute facilities with proper support available in the community.

Crisis accommodation, providing places for people in the short term, was only available in 39% of areas. Crisis resolution home treatment (CRHT) teams provide intensive support to people during a mental health crisis in community settings and have a key role in acting as the gatekeeper to identify whether an alternative to admission is appropriate. Over a six-month period, CRHT teams acted as gatekeepers in only 61% of the 39,223 admissions to acute wards, varying between trusts from 9% to 100% of admissions.

These teams also help people to leave hospital while they are still in an acute phase of their illness but, over the same period, only a quarter of the 39,801 discharges from acute wards occurred early with support from CRHT teams, ranging from 0% to 70%. As part of our 2008/2009 annual health check, we will be including an indicator on the gatekeeping of admissions by CRHT teams to ensure further improvements are made.

A third of all care records sampled for the review (33%) showed that community care coordinators provided input into the service user's care review meetings only "some of the time" or "none of the time". Over a six-month period, 6% of all the days that people spent in mental health hospital was time when their discharge was delayed due either to accommodation issues or as a result of health or social services needing to put appropriate support in place. In 2006/2007, 86% of people on enhanced care programme approach were followed up within seven days of leaving hospital. Over a nine-month period, 6% of services users were re-admitted to hospital because of their mental health problem within a month of being discharged.

Commissioners and providers of mental health services need to take action to increase the effectiveness of the acute care pathway. They

should focus on:

- Developing the role and functions of the crisis resolution home treatment teams within the context of a clear integrated care pathway.
- Extending access to a range of services to help people in a crisis.
- Ensuring that local area agreements require the development of locally agreed protocols, systems and resources to ensure a timely and safe discharge.

Recommendations

To achieve improvement in the priority areas identified, we have four key recommendations.

1. Develop the quality of commissioning acute care services

Health and social care commissioners should:

- Ensure that the commissioning of acute care services is based on assessment of local needs and makes best use of local partnerships and other opportunities.
- Ensure that acute care priorities and the acute care pathway approach are reflected in the standard contract for mental health.
- Be an active member of the acute care forum, attending key meetings to evaluate progress.
- Adopt an integrated approach across the acute care pathway and between PCTs and local authorities.
- Develop and use a performance management framework based on the framework of assessment for this review, to monitor local progress and inform future commissioning decisions about acute care.

2. Increase the strategic priority given to acute care services as part of the overall pathway

Providers and commissioners of mental health services should:

- Increase the profile of acute care services within their trust's board, local implementation teams and in clinical governance committees, so that the acute care forums can institute change.
- Embed the involvement of service users and carers, including those from groups with diverse needs, in any strategic development processes.

Acute care forums should:

- Develop locally agreed multi-agency protocols that clarify the role and purpose of the key components of the acute care pathway, paying particular attention to the specific care pathways for people from black and minority ethnic groups and people with complex needs.
- Monitor the effectiveness of the acute care services and the acute care pathway.

Local strategic partnerships should:

- Ensure that the comprehensive area assessment adequately takes account of the priorities within acute care services.
- Designate board level responsibility for implementing partnership arrangements for acute care.
- Review the availability of services to help people in crisis, to assess the adequacy of provision in meeting local needs.
- Review the availability of systems and resources to ensure a timely and safe discharge.

- Ensure that acute care services have access to specialist advice to support staff to work with people with diverse needs.

The Department of Health should:

- Review the guidance on acute care forums and acute care policy implementation, to ensure that these reflect the need to deliver services as part of an integrated acute care pathway.
- Ensure that the priorities identified in this report are incorporated into the future strategy for mental health.
- Together with strategic health authorities, ensure that a national and regional focus on acute care is sustained, and that trusts are supported to build on learning from the review.

3. Develop effective leadership and workforce capability at all levels

Mental health providers should:

- Ensure that there is an integrated approach to the management of acute care services, to enable effective coordination between community-based and inpatient services and between the components of the acute care pathway.
- Support operational managers to institute change.
- Enhance the skills of ward managers, team leaders and lead consultants, and strengthen clinical leadership.
- Sustain a focus on clinical supervision.
- Monitor and increase the amount of time staff spend with service users and the provision of evening and weekend activities, to maximise therapeutic engagement, promote safety and support recovery.

Mental health providers and commissioners should:

- Review the capacity, capability and skill mix of staff and the input from multi-disciplinary teams across the acute care pathway on an ongoing basis, to ensure that needs are met.
- Address gaps in training and personal development, particularly in relation to training in sexual safety awareness, working with people with a dual diagnosis, working with people from black and minority ethnic groups, working with families and carers, and the legal and ethical framework within which acute care is delivered: the Human Rights Act, the Mental Capacity Act and the Mental Health Act.

The Department of Health, regulatory bodies and royal colleges should:

- Address gaps in pre and post-registration training and personal development.

4. Develop the availability and robustness of data to enable monitoring and evaluation of services

The Department of Health information centre and regulatory bodies should:

- Review the quality and focus of national data sets and regulatory assessments to identify gaps and duplication.
- Develop the range of meaningful outcome indicators, building on our framework of assessment for monitoring and assessing local and national progress and to support commissioning.
- Establish a data source that reflects the experience of those who use acute care services.

This publication is available in other formats and languages on request. Please telephone 0845 601 3012.

આ માહિતી વિનંતી કરવાથી અન્ય રૂપે અને ભાષાઓમાં મળી શકે છે.
મહેરબાની કરી ટેલિફોન નંબર 0845 601 3012 પર ફોન કરો.

GUJARATI

ਇਹ ਜਾਣਕਾਰੀ ਬਿਨਤੀ ਕਰਨ 'ਤੇ ਹੋਰਨਾਂ ਰੂਪ 'ਚ ਅਤੇ ਜ਼ਬਾਨਾਂ 'ਚ ਮਿਲ ਸਕਦੀ ਹੈ।
ਕ੍ਰਿਪਾ ਕਰਕੇ ਟੈਲਿਫੋਨ ਨੰਬਰ 0845 601 3012 'ਤੇ ਫੋਨ ਕਰੋ।

PUNJABI

यह जानकारी बिनती करने पर अन्य रूप में और भाषाओं में मिल सकती है।
कृपया टैलिफोन नम्बर 0845 601 3012 पर फ़ोन करें।

HINDI

Akhbaartan waxaa lagu helaa iyadoo
siyaabo iyo luqado kale ku qoran haddii la
codsado. Fadlan soo wac lambarka telefoon
ee ah 0845 601 3012.

SOMALI

Οι παρούσες πληροφορίες διατίθενται και σε
άλλες μορφές ή γλώσσες εάν ζητηθεί.
Τηλεφωνήστε στο 0845 601 3012

GREEK

المعلومات متاحة أيضاً لدى طلبها بعدد من الأشكال واللغات الأخرى.
الرجاء الإتصال بهاتف رقم 0845 601 3012.

ARABIC

یہ معلومات درخواست کرنے پر دوسرے فارمیٹ یعنی شکلوں میں بھی دستیاب کی جاسکتی ہے۔
برائے مہربانی فون کیجئے 0845 601 3012

URDU

如有需要，本信息还有其他格式和语言的版本。
请致电 0845 601 3012。

CHINESE-SIMPLIFIED

如有需要，本信息還有其他格式和語言的版本。
請致電 0845 601 3012。

CHINESE-TRADITIONAL

অনুরোধ করলে এই তথ্যগুলি অন্য ভাষা ও আকৃতিতে পাওয়া যাবে।
অনুগ্রহ করে এই নাম্বারে ফোন করুন 0845 601 3012

BENGALI

Arzu edildiği takdirde bu bilgi değişik
formatlarda ve dillerde verilebilir.
Lütfen 0845 601 3012 numaralı
telefonu arayınız.

TURKISH

Tin tức này có bằng những hình thức và ngôn
ngữ khác theo yêu cầu.
Hãy gọi phone số 0845 601 3012

VIETNAMESE

È possibile richiedere le presenti informazioni
su altri supporti o in altre lingue. A tal fine,
telefonare allo 0845 6013012.

ITALIAN

Informacje te są dostępne na życzenie w
innych formatach i językach.
Prosimy zadzwonić pod numer 0845 601 3012

POLISH

Healthcare Commission

Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Maid Marian House
56 Hounds Gate
Nottingham
NG1 6BE

Dominions House
Lime Kiln Close
Stoke Gifford
Bristol
BS34 8SR

Kernel House
Killingbeck Drive
Killingbeck
Leeds
LS14 6UF

5th Floor
Peter House
Oxford Street
Manchester
M1 5AX

1st Floor
1 Friarsgate
1011 Stratford Road
Solihull
B90 4AG

Telephone 020 7448 9200
Facsimile 020 7448 9222
Helpline 0845 601 3012

E-mail feedback@healthcarecommission.org.uk
Website www.healthcarecommission.org.uk

This publication is printed on paper made
from a minimum of 75% recycled fibre

ISBN 978-1-84562-199-5



9 781845 621995



Corporate member of
Plain English Campaign
Committed to clearer communication.

341