

## **Acute Care Commission: General Adult Faculty Final Response**

The Faculty Executive Committee (chaired by Dr Paul Rowlands) met on 4 March 2015 to specifically discuss the provision of inpatient care. In addition, the General Adult Faculty conducted a members' survey and collected 638 responses from across the UK. The Faculty response below is the culmination of both the Faculty discussion and wider Faculty survey. A number of themes emerged from the survey, including inadequate resources, a lack of supported housing and the importance of continuity of care.

We are happy to allow access to the raw data from this survey. Please contact Lauren Wright (RCPsych) or Dr Paul Rowlands (contact details can be found at the end of this document).

### **Q1.**

In your opinion, what is the **value** and **purpose** of inpatient mental health care for adults?

We are interested in hearing your views on the importance, worth, or usefulness of inpatient care. Please explain your answer (*word limit 500 words*).

Acute inpatient care forms an essential component of an interlocking system needed to deliver comprehensive mental health care. Whilst a small minority of patients in contact with services will require these services, the system as a whole cannot function without adequate resource in this area. At the same time, it should be recognised that at times inpatient care can be counter-productive, leading to decompensation and deterioration in some patients. A recognition therefore that the role of inpatient care may be different in different patient groups is important and all admissions should have a clear purpose.

The Faculty supports the Department of Health statement on the purpose of inpatient care and would describe the goal of inpatient care as:

*“To deliver collaboratively as far as possible compassionate, safe and therapeutic interventions to enable an individual to recover function to the point that they can reside in a less dependent setting”*

Whilst safety is an important component of this definition, it should be recognised that judgements in this area are extremely difficult and paradoxically overly coercive approaches with certain diagnostic groups (such as those diagnosed with “personality disorder”) can have the effect of increasing risk in the short as well as the medium and long term through reinforcement of patterns of unstable and chaotic attachment and through setting up potentially adversarial therapeutic interactions. At other times, in other contexts, inpatient care can be lifesaving.

For some patients a longer period of inpatient care may allow necessary space and time for formulation and diagnostic evaluation enabling an effective longer term plan of management to be developed, a long enough period of initial inpatient care can be a way of preventing recurrent admissions for example by enabling someone to recover to a point

where they are able to engage in an effective post-discharge care plan and avoid or break a pattern of recurrent admission.

Availability of timely and local access to acute inpatient care enables other components of the mental healthcare system to function safely and with proper regard to wider issues such as the needs of patients, carers and the wider neighbourhood. Whilst many patients never require this resource, failing to provide it adequately inevitably impacts on all aspects of the wider system, increasing waste, reducing quality and reducing the safety of services.

Similarly, a small number of patients, usually with complex psychotic conditions, benefit from a more extended period of inpatient care as they recover. For many patients the availability of such extended in-patient stays in 'open' rehabilitation has become less accessible. The availability of timely and local access to such extended recovery provision is again an essential component of a well functioning service as otherwise such individuals will potentially either be discharged prematurely, with risk of rapid readmission with all its associated distress or spend extended periods in an acute ward setting that is not best placed to meet their needs. Worse still, such patients can in a minority of cases eventually end up in secure services where typically they will receive a high cost intervention over an extended timescale.

## Q2.

Please can you provide an example of:

- 'good' inpatient care
- 'good' alternatives to inpatient care?

Please explain your answer, and give as much detail as possible about what made the care 'good'. Please also tell us **where** and **when** this example is from (e.g. *Manchester, 2012*).

The experience of the General Adult Faculty Executive and the results of our members' survey suggest that there are many examples of good inpatient care although also it is clearly the case that many areas are struggling with the development of a vortex of overloaded acute services impacting on the wider function and well being of other parts of the mental health system.

The creation of 'capacity' at each stage of the patient journey is a necessary aspect of system design. Without this, care is not available in a timely fashion with resultant delays, poor quality and inefficiency.

The following services are examples of good practice:

**East London Trust:** This Trust manages without needing to use OOA beds and in fact provides inpatient care to patients from other parts of London within its spare capacity. It has retained Consultants providing continuity of care between inpatient and community services. Staff describe high levels of satisfaction and morale and attending to this aspect of creating resilience in staff groups is a vital aspect of creating good inpatient environments.

**Tees Esk and Wear Valleys NHS Foundation Trust:** The diagram on page 10 of the Commission's background briefing paper describes the attention to understanding the flow of an inpatient admission using Quality Improvement methodologies that has been employed within Tees Esk and Wear Valleys NHS Foundation Trust. This has seen an increased efficiency in the use of the inpatient resource and the service describes not having to use OOA beds and having well motivated staff groups. This Trust does have separate inpatient consultants.

Tees Esk and Wear Valleys NHS Foundation Trust have also been developing a 'trauma-informed' approach to care, recognizing the large proportion of inpatients who have suffered abuse.

**Derbyshire Healthcare NHS FT:** This Trust, covering Derbyshire with two main population centres and two inpatient units in Chesterfield (in the North) and Derby (in the South). The Trust provides a daily update of its bed usage both within and outside the Trust in a simple form for all clinical staff. The North, with well developed, experienced community teams uses approximately 75% of its available inpatient capacity at any one time. It has well motivated inpatient staff groups who have pioneered the development of staff support through reflective groups for staff ("Schwartz Rounds"). It has assertive in-reach to the acute wards from community teams, the inpatient consultant presents in the community team meeting each week and between 2003 and 2010 developed a 'discharge liaison nurse' role managed from within the CMHT to pick up immediately patients admitted who did not have existing community support. However, the available excess bed capacity tends to be filled with patients from outside the locality resulting in disruption to the local service. Results from the General Adult Faculty survey suggest that this may be a pattern replicated elsewhere.

**Lothian:** Lothian describe an effective in-reach service and also the effective use of acute day hospitals as an alternative to admission.

Good alternatives to acute inpatient care include the availability of 'step-down' placements either in supported community settings or in hospital recovery or rehabilitation settings for patients who have been admitted to acute settings as well as the timely availability of support for those able to return to their own accommodation.

Crisis and Home Treatment teams can provide effective alternatives to admission as well as assertive in-reach. These services however must actively work on their interfaces with other teams to be effective.

### Q3.

Giving as much detail as possible, please can you:

- provide an example of '**poor**' inpatient care
- explain how that poor inpatient care could be **improved**?

Please explain your answer, and give as much detail as possible about what made the care 'poor'. Please also tell us **where** and **when** this example is from (e.g. *Cardiff, 2014*).

The results from the Faculty survey of members demonstrated that there is not a uniform picture across the UK. Out of over 600 respondents to the survey (over 70% consultants), 54% said that they 'regularly' encountered difficulties in accessing local inpatient beds when needed whilst only 9% said they had not had this problem in the last year. There are clearly areas where a vicious cycle has developed with patients frequently needing to travel hundreds of miles to access an open acute bed (i.e. not for specialised care). There are many examples: two for example were given of a patient from Dorset being admitted to Bradford and a patient from Leeds being admitted to Weston-super-Mare. Sometimes there are prolonged waits in Police stations for patients needing a PICU bed. Such patterns of service mitigate against patient-centred care, increase risks and increase costs. Whilst receiving this care, patients are distant from family and friends and distant from the teams and services who will be expected to construct with the patient an appropriate package of aftercare.

There are problems implementing MHA admissions when a patient's need for admission has to be balanced against the disadvantages of admission a long distance away. A recent example from NW England: a patient on CTO was not recalled to hospital because the nearest bed was 200 miles away; subsequently when a bed was found; recall papers had to be reissued because the bed the patient was recalled to was given to another patient. There are also delays in detaining people on sections where the hospital of admission has to be stated at the time of detention – e.g. when the doctor who has assessed the patient is not at work when the bed becomes available.

There has unquestionably been a rise in this use of Out of Area beds generally but as noted above this is not universal. When it has occurred services potentially enter a cycle of fragmentation of care, deteriorating morale and a passive acceptance of this is the way it has to be. This was evident in some of the text answers in the survey - a respondent from Manchester said this had been a feature of the service for many years and across the UK overall 33% of respondents described the use of OOA beds as a feature of their service at present. The problem was described as worse than it was ten years ago by nearly three quarters of respondents whereas only 4% described it as better than it was.

Poor quality services are associated with high staff turnover, a lack of clear purpose and with that underdeveloped standard operating procedures. A high use of locum/agency and bank staff, high rates of sickness are typical and there is often a limited availability of constructive daytime occupation for patients, isolation from other parts of the service and a lack of attention to the interfaces with other teams needed to deliver effective care. There may be tolerance of assaults and tolerance of the use of alcohol and drugs by patients creating a toxic atmosphere. Aspects of care such as management of physical co-morbidity are likely to be less than optimal.

Many parts of the UK appear to be impeded in their delivery of care by electronic record systems that do not function in ways that make the jobs of staff easier.

## **Improving poor inpatient care**

Once a service has entered such a spiral of poor care and low morale, remediating the situation is likely to require considerable expenditure of effort and resource. This must include understanding the entirety of the system within which the inpatient unit operates but also requires attention towards enhancing staff morale and enabling systems of support to be available to staff.

Feedback from patients who have used inpatient services suggest two things which can contribute to positive patient perceptions of inpatient stays are:

- (1) Positive staff attitudes, kindness, and the ability to offer time to talk and
- (2) Availability of meaningful daytime activity.

Cultivating a culture that allows this to flourish is a key organisational task for any provider of inpatient care.

Some services manage to avoid acute inpatient care being predominantly about biological treatment and risk management and achieve a much more genuinely biopsychosocial model. Enabling inpatients to have ready access to specialist psychological input is an important part of this, and developing psychologically minded therapeutic approaches amongst front line staff on wards (who are mainly nurses and healthcare assistants) requiring resources, focus, time for staff to reflect on the often difficult nature of their work.

As an acute admission is generally a time of crisis, there can sometimes be a window of opportunity for psychological work at this point, including with families. The current model of an acute inpatient unit is not the only model available for managing acute presentations, but any new models require proper evaluation.

An admission is also a point at which a full review of an individual's physical health can take place and this should form part of the flow of the admission with timely investigation and intervention and availability of any results. The Faculty is contributing to an Intercollegiate Group investigating how to improve this aspect of care delivery and many organisations are providing educational and training resources to try to improve staff skills and confidence in this.

Whichever model is adopted, collaborative approaches between professionals, patients and their families should be the preferred approach.

The creation of a therapeutic milieu is essential with a clear purpose for admissions and clear protocols and expectations. East London provides GP clinics to the inpatient wards to ensure proper attention to physical health issues. Walsall provides employment retention workers and facilities for inpatients to be able to use a gym. Tees, Esk and Wear Valleys NHS Foundation Trust provide a clear inpatient pathway protocol. Derbyshire provides a physical health framework and a 'hub' providing day time activities.

The RCPsych inpatient accreditation scheme provides a means by which inpatient units can receive formative feedback to enable them to make incremental improvements.

Multidisciplinary working is a potential strength of inpatient care with psychiatrists, nursing staff, clinical psychologists and pharmacists coming together to develop and action a shared, collaborative formulation and management plan. This requires adequate staff resources and good communication.

Inpatient care is usually part of the patient's journey. Care can be improved by recognising this and by facilitating an ethos of active engagement with professionals from outside the immediate ward team who are thus encouraged and able to actively work with the patient and the inpatient team throughout the admission. These professionals may be, for instance, from primary care, community mental health teams, rehab services, crisis intervention teams and EIP. This 'in reach' function is a crucial element in making functionalised systems work.

#### Q4.

Giving as much detail as possible, please can you:

- provide an example of a '**poor**' alternative to inpatient care
- explain how that poor alternative to inpatient care could be **improved**?

Please explain your answer, and give as much detail as possible about what made the care 'poor'. Please also tell us **where** and **when** this example is from (e.g. *Belfast, 2013*).

On many occasions in many, though not all, parts of the country, an inpatient bed is often not available when needed. Poor alternatives to inpatient care are characterised by a lack of attention to the experience of continuity of care from the patient perspective and a resulting disorganised response. Multiple professionals seeing the same patient and repeating assessments whilst leaving a sense that 'no one is in charge' is inherently unsatisfactory and wasteful of resources. Examples were given to the Faculty of patients having three full 'assessments' within the course of a few hours with no ongoing joint ownership of the case and of patients being passed between teams with little sense of how this feels from the perspective of the patient. The balance between 'continuity' and 'immediate availability' is of course a difficult circle to square but current service configurations in some areas appear to have sacrificed the concept of continuity to achieve what is perceived as accessibility with unsatisfactory results.

In many services, there has been a reduction in the longer term community resources available. This longer term continuity is potentially an important contribution to reducing demand on acute resources but recent investment has focused more on assessment and short term intervention than the longer term intervention that might be necessary for effective reduction in acute demand.

The Faculty would support a number of ways of leveraging improvement.

- Systems must make it easier for staff to do the right thing. This must include improvement in the IT systems to reduce the amount of time that staff spend documenting within outdated electronic records. Examples were given of staff needing two hours to document a one hour

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assessment using the RIO system and similar inefficiency is built into the PARIS system. Positive examples were given of staff using electronic dictation to reduce the burden of administrative work. At present dictation is used mainly by medical staff - extending this to other disciplines could potentially eliminate large amounts of waste within the existing system.

- All management roles (at every level) should include a clinical role as a component of the job plan to prevent the development of a detachment of management from an understanding of the reality at ground level of the services that they are running.
- Understanding the flow through the system using Quality Improvement methodologies and concepts such as 'pull' should inform the development of work at service interfaces. A technique such as Value Stream Mapping can be helpful in analysing this process. The patient should be seen as the centre of the 'value-stream' of the process and the whole system needs to be focused on how 'value' can be added for the patient.
- Nurturing staff groups and providing space for reflection should be given due priority. Front-line staff work in inherently risky and uncertain situations and many fear judgement after the event by individuals who themselves have little or no experience of being in the clinical situations they encounter on a daily basis.

#### Q5.

In your opinion, what would be the **best way of measuring 'good quality' care** on an inpatient ward, or in an alternative to inpatient care?

In other words, what should we measure? And how should we measure it?

- Patient rated outcomes are a cornerstone of this and should be routinely taken at the point of discharge.
- Length of stay.
- Readmission rates within 28 days but also readmission within 3 months, 6 months, 12 months and 24 months. Such measures would give an indication of the wider health of the whole system.
- Other patient outcomes that could be considered as part of a wider suite would need to be considered in their local or comparable contexts but could include mortality and employment rates as well as numbers of patients progressing into secure services.
- Services should also be measured on their use of OOA beds for routine acute IP care.

Other important proxy measures of quality of care should include:

- Staff satisfaction ratings.
- Rates of sickness.
- Rates of staff turnover.

#### Q6.

In your experience, do inpatient wards and alternatives to inpatient care services work well for all patients/service users? Or are there some groups (such as adults from some BME communities or

other adult groups) that inpatient and crisis services do not work well for? Please give as much detail as possible.

This varies.

**Q7.**

We are keen to hear about any examples of good practice, service evaluations, research reports, data-sets, or other information that would help the Commission in its work.

Please take the opportunity below to let us know where we could obtain this information, including any contact details of the organisation/person that it can be obtained from.

Please contact Lauren Wright (Faculty Manager) at [lwright@rcpsych.ac.uk](mailto:lwright@rcpsych.ac.uk) **or**

Dr Paul Rowlands (Faculty Chair) at [Paul.Rowlands@derbyshcft.nhs.uk](mailto:Paul.Rowlands@derbyshcft.nhs.uk)

We would be happy to make available our survey and could also provide contacts to other organisations.