Delivering Quality and Value

Focus on: Acute Admissions in Adult Mental Health
Introduction

This document aims to help local health communities and organisations improve the quality and value of care for acute adult mental health patients. It is one of a series of documents produced by the Delivering Quality and Value team at the NHS Institute for Innovation and Improvement as part of the high volume Healthcare Resource Groups (HRG) programme.

The programme is based on the concept that by focusing on a limited range of high volume HRGs (or related care groups), the NHS Institute can help the NHS to make the maximum impact on improving the quality and value of care for NHS patients.

The initial series of HRGs (or related patient groupings) were chosen on the basis that they were high volume, and hence high resource consumers, and also represented a range of clinical areas.

The series of HRGs chosen were:
- acute admissions in adult mental health
- acute stroke
- Caesarean section
- fractured neck of femur
- cholecystectomy
- short stay emergency care (length of stay two days or less)
- urinary tract infections (as a tracker condition for frail elderly patients)
- primary hip and knee replacement.

The document covers:
- the Delivering Quality and Value team’s approach
- the key characteristics of organisations providing high quality care and value for money
- measures for improvement
- further information.

HRGs are groups of clinically similar activities for which a similar quantity of resources is needed. They are also the basis for the NHS Payment by Results system.

50 HRGs account for 50% of all bed days. 50 different HRGs (however, there is overlap) account for 50% of all finished consultant episodes (FCEs). As the graph shows, a relatively small number of HRGs account for a large proportion of NHS resources.
The approach

A literature review was undertaken of the recognised evidence in delivering optimised care for acute adult mental health patients. The ‘Further information’ section gives further detail of the documentary evidence.

A thorough data analysis was undertaken using nationally available data from Hospital Episode Statistics (HES) as an indicator to rank and identify organisations.

The initial statistics were then adjusted for deprivation levels, mortality rate and readmission rates.

After we reviewed the data analysis, it became evident that the national data was going to be insufficient. While analyses of length of stay and volume can be meaningful indicators of performance in many secondary care specialties, this is less true for mental health.

We held discussions about the scope of the project, and worked with the office of the National Clinical Director for Mental Health and with the Department of Health’s Care Services Improvement Partnership (CSIP) - encompassing what was formerly the National Institute for Mental Health in England (NIMHE) - to choose appropriate co-production partner mental health and social care trusts.

We then chose trusts based on the recommendations of experts who had knowledge of where there was innovation and good practice within the acute admission and discharge process. We tried to get a representative cross-section of different communities, and have obtained comments on our findings from a broad range of mental health and social care trusts and individuals.

Verifying the selection of organisations

Having identified the local health and social care communities, we then approached the organisations to allow us to visit them and observe how they manage this group of patients. The ‘Acknowledgements’ section lists the organisations we visited. The information contained within this pathway was only possible because health and social care communities allowed us to see their practice.

We then undertook site visits, ensuring that at least 50% of our time was spent observing, watching, listening and looking at the flow and processes of care. We also explored the use of information to aid clinical and non-clinical decision making. The remaining time was spent conducting a series of semi-structured interviews with key members of staff across the pathway of care (including a range of clinical staff, porters, ambulance staff, pharmacy staff, social care staff, primary care staff, community services staff and commissioners), and with patients. In total we interviewed or observed 160 staff and patients.

The knowledge we gained from these visits and the co-production events\(^1\) was then consolidated, and the optimised pathway of care illustrated later in the document was identified.

We worked in partnership with the NHS throughout this project to validate the pathway and the knowledge gained from the site visits, and to identify measures for improvement that would be helpful indicators for evaluating the impact of change.

Prototypes have been identified and tested with the NHS to maximise adoption. Some of these will follow on from the publication of this document (referred to in the conclusion). The key characteristics for delivering optimal care in the NHS have been tested with the organisations we worked with and others, to ensure that the change in practice is understood, is relevant and appropriate, and that measuring the improvement is possible within a short time frame.

\(^1\) Co-production with the NHS, involving all sites visited and national bodies and experts relevant to the pathway
How to use this document

The content of this document has been developed with the help of NHS staff for the benefit of any organisations and stakeholders that play any part in the acute admissions in adult mental health pathway.

Key characteristics have been developed with the expectation that they will be widely adopted across the NHS, so that patients receive a high quality experience irrespective of where they receive their care.

The majority of improvements are applicable and easily transferable to other pathways, and implementation will have numerous benefits for the patient and all health and social care services.

Our aim is to suggest ways to ensure prompt care and treatment of acute adult mental health patients. We would like you to read this document carefully and consider using these ideas as a means of improving the care and treatment of these patients, therefore improving their health outcomes.

This document should be viewed in the context of other work that has been undertaken by the Royal College of Psychiatrists, Care Services Improvement Partnership (CSIP), the Healthcare Commission, the National Patient Safety Agency and Star Wards, as there are a number of correlations with their findings and recommendations.
Acute admissions in adult mental health pathway

Context

Current national mental health policy, driven by the 1999 National Service Framework (NSF), subsequent Mental Health Policy Implementation Guides and national targets have directed local services to invest in community alternatives to acute inpatient care. This aims to improve quality of care and reduce the need for inpatient admission - as well as the length of stay - for the majority of acutely ill people.

For far too long, there has been much criticism regarding the quality of inpatient stays. Staff need to be enabled to develop the skills, enthusiasm and time to offer what is a truly therapeutic experience, even though the patients they are working with are often critically ill.

A truly therapeutic experience needs to be available to those patients who would ideally be moving on to different accommodation settings, so that all can achieve the highest level of recovery.

It has recently been recognised that the demands put on inpatient services have changed considerably: those requiring admission tend to be the least well and lacking adequate care and accommodation. In addition, many of the most experienced staff have migrated to work within new community settings, leaving less experienced staff on wards.

Investment in developing staff needs to be given high priority if we are to see the sorts of improvements that service users, carers and staff expect.

Acute home treatment, assertive outreach teams and other community developments have in many places dramatically reduced the demand for acute beds. In some areas, this has led to the closure of wards or has removed the demand for private facilities to complement bed numbers.

These developments have had little impact on those patients for whom alternative and more appropriate accommodation cannot be found, however, and the mean length of stay has not been significantly reduced. Hospital Episode Statistics report that the mean length of stay for adult mental illness has remained relatively steady, rising from 52.5 days in 2002/03 to 55.7 in 2004/05.

It is vital that the inpatient environment changes in two main ways: structurally and therapeutically.

Over the past three decades, most inpatient services were moved from the old mental health institutions. Their replacements were not always purpose-built, however. Some of those that were purpose-built fail to meet current standards (such as providing single en suite bedrooms and single-sex lounges). Considerable work has been carried out in the last few years to reduce the risk of successful inpatient suicides, but many buildings nevertheless remain unfit for purpose.

Where it is proving impossible to create single bedrooms, units are moving towards single-sex wards. This is achievable in those units with more than one ward, but will impact on the flexibility of bed usage.

The plan to introduce a smoking ban within the buildings will present further challenges. Even those buildings with immediate access to the outdoors do not tend to have absconsion-free gardens, so more challenging patients are unlikely to be able to access designated smoking areas.
Current service recommendations

National variation in bed usage depends very much on the local socio-demographic measures as well as on services available across health, social care and the voluntary and private sectors.

Care delivered at home is both cheaper and usually more acceptable to service users and their carers. However, inpatient care is needed in some instances, albeit generally for shorter periods than in the past.

The 10 High Impact Changes for Mental Health document\(^2\) makes the following recommendations:

- Treat home-based care and support as the norm for the delivery of mental health services.
- Improve the flow of service users and carers across health and social care by improving access to screening and assessment.
- Manage the variation in service user discharge processes.
- Manage the variation in access to all mental health services.
- Avoid unnecessary contact for service users and provide necessary contact in the right setting.
- Increase the reliability of interventions by designing care around what is known to work and that service users and carers inform and influence.
- Apply a systematic approach to enable the recovery of people with long-term conditions.
- Improve service user flow by removing queues.
- Optimise service user and carer flow through the service using an integrated care pathway approach.
- Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce.

\(^2\) Care Services Improvement Partnership (2006), 10 High Impact Changes for Mental Health Services, National Institute for Mental Health in England, Leeds (www.nimhe.csip.org.uk/10highimpactchanges)
This pathway illustrates how patients should be treated in order for a trust to achieve optimal health outcomes and, as a result, better value for money. Based on comments received during co-production, we have tried to portray as non-linear a pathway as possible. The groupings indicate that the elements of that part of the pathway may happen concurrently, at any time during the stage, or potentially may not happen at all, depending on individual need. The blocks across the pathway stages indicate activities that are continuous.
The key characteristics of organisations providing high quality care and value for money

The following characteristics have been found to be the key features for delivering quality and value for acute adult mental health patients. They are followed by suggested measures for improvement. The suggested measures for improvement are those that we judge to be of value to organisations to enable them to benchmark their current practice against the characteristics described and to further improve it.
1. At one hospital, we observed the use of multi-professional case notes. All disciplines contribute to the assessment, and record and update their notes in one place. This has improved communication between staff and has led to the capture of more precise - and therefore more valuable - information. In the past, staff had to search for information kept in a variety of case files in more than one room.

2. At one hospital, multi-professional case notes are now held on computer only - the records have become truly paperless.

3. At another hospital, an effective relationship has been developed between staff in A&E and those in the acute mental health service. This has resulted in service users having their needs met in a sensitive manner that complies with previously agreed care plans. A special service has also been developed for a particular client group so that they are no longer admitted in crisis: they do not themselves experience disruption, but nor do they disrupt the care of other inpatients. This development includes a clear care pathway for people with borderline personality disorders, as well as an ongoing educational programme for staff in A&E and for new staff in mental health.

4. One service has clear guidelines for staff regarding the management of conflict between disciplines. This ensures that senior colleagues are involved in providing speedy second opinions and in arbitration, in order to enable the best outcome for service users. Staff have easy access to senior nursing and medical staff, and both are seen as friendly and approachable.
Trusts have robust clinical leadership.

- Practice development leads are responsible for ensuring the ongoing education and development of all staff.
- Equal value is placed on nursing and other professional groups.

Observations

1. We observed a service in which there is no longer an ‘us and them’ culture between nursing and medical staff: traditional roles are genuinely blurred. Nurses now lead ward rounds and are trained to carry out all components of an assessment, including mental state examinations.

2. In another service, the modern matron ensures ongoing practice development of all staff, which is supported by robust supervision, appraisal and personal development plans (PDPs).
Alternatives to admission are used when possible. Staff plan proactively for discharge and overcome barriers when admission is necessary.

- 24/7 crisis resolution and home treatment team services are offered.
- Direct payments are used to maintain accommodation that does not comply with regulations.
- There is active bed management, including a ‘traffic light’ system to identify readiness for discharge.
- Discharge liaison nurses monitor breaches as part of their role.
- Crisis teams transfer patients out of hospital beds without the need for input from medical staff, recognising that transfer to home treatment care is not discharge.

Observations

1. In one service, a senior professional works at night to triage all requests for urgent assessments/admissions. This role supports junior and senior medical staff, and means that staff on rota can be called in to assist in assessments and home management, supporting the decision to admit when necessary.

2. In another service, pooled budgets are used to provide direct payments, allowing service users to pay for residential and other care that suits their needs but does not necessarily comply with current registration standards. This has meant that service users have not had to leave accommodation just because the size of their room does not meet the new standards, for example.

3. Some services have a clearly defined bed manager role (held either by one individual or operated on a rota basis), showing that this is a vital component in managing the use of acute beds. The role involves regularly reviewing all inpatients, establishing their readiness for discharge and recording this using a traffic light system.

4. Another service has a well defined discharge liaison post. This is designed to ensure that all obstacles to discharge are managed in conjunction with the service user, and that they are also supported in their reintegration into the community.
There is effective multidisciplinary working and training.

- All potential referrers are trained in mental illness in order to target all referrals effectively.
- Staff are rotated between wards and home treatment teams in order to develop their skills and confidence.
- Electronic care plans are used where appropriate.
- Electronic referrals are made, with the ability to integrate information into the electronic health record.
- Senior house officers receive training in order to avoid unnecessary admissions.
- Nurses are trained to carry out mental state examinations to the standard expected of a junior doctor.

Observations

1. In one service, staff moved freely from inpatient into home treatment teams. This is particularly easy where both teams are co-located, and the process is enabled by clearly defined rotations for staff between the two teams, either on a part-week-by-part-week basis or for several weeks at a time.

2. We also observed services in which the wards, day hospitals and home treatment teams are all part of one unit of management, facilitating the sharing of resources, etc.

3. We also observed a service that runs regular training for police and custody staff, with the aim of reducing the inappropriate use of section 136 and encouraging good practice within the custody suite.
• Approved social workers explain the reasons for compulsory admission when it happens.
• During admission, there is continued involvement from the assertive outreach team, the home treatment team and the community mental health team.
• Medical staff dedicated to the home treatment team take over responsibility as soon as patients are transferred from inpatient care, providing as much continuity of care across the pathway as is feasible.
• There are clear interface pathways between the various age groups.
Services are focused on users and carers.

- There is an active five days per week advocacy service.
- There is protected therapeutic time, ensuring that other staff, including medical staff, cannot disturb it.
- All information provided is clear and effective.
- A holistic response is taken to people’s needs, including a sensitive approach to gender, ethnicity, race and culture.
- Crisis cards are made available. These can be subsumed in the Care Programme Approach (CPA) crisis plan, which is agreed with the service user and is available to them, their carers and other professionals in both paper and electronic forms.
- Integrated service user assessments are provided.
- Brief assessment summaries are given to the service user.

Observations

1. At one hospital, user influence ensures that those involved in completing the application for compulsory admission visit patients after admission in order to explain the reasons for the decision face to face.

2. At another hospital, care coordinators from assertive outreach, home treatment and community mental health teams all maintain input while their client is an inpatient. This provides continuity and familiarity, and speeds up the process of discharge.

3. Other examples include those in which the whole assertive outreach team - including medical staff - remains responsible for clients’ care while they are in hospital, or where the medical team from home treatment remains responsible for a defined period of time from admission onwards, or until it is clear that it will be a fairly long admission.
Care is high quality and effective, and includes psychological interventions.

- There is protected time for meals and therapeutic sessions, ensuring that other staff, including medical staff, cannot disturb it.
- Ward rounds are nurse-led.
- Concordance therapy is actively promoted to both patients and carers.
- A robust range of meaningful activities is available.
- There is psychological support for patients and supervision for staff.

Observations

1. At one hospital, we observed that a service user advocate is a key member of the multidisciplinary acute home treatment team.

2. In another area, there is finance to employ a full-time carer advocate, and this advocate distributes literature.

3. We have also observed services in which patients and staff cannot be disturbed by other members of staff or by visitors during mealtimes.

4. Activity time and one-to-one time is protected in some services, and cannot be disturbed by anyone. Staff have input into the rota so that they can lead the activities in which they are most interested. This has ensured that a continuous programme of activities is maintained.
There is appropriate safety and risk management.

- Skills development is mandatory for all inpatient staff.
- There is a close working relationship between members of the home treatment team, and ward and day hospital staff.
- A balanced approach to risk taking is supported from the top of the organisation.
- There is an excellent relationship with the police.
- Clinical pharmacists and technicians review prescribed medication and advise both staff and users on these (and any other medications being taken).

Observations

1. In one trust, the senior nurse regularly ‘chairs’ the ward rounds. It is recognised that this role does not have to lie with the consultant, but should be taken on by the most appropriate professional.

2. We observed one inpatient ward that runs a comprehensive range of daytime, evening and weekend activities and therapeutic groups. Staff are encouraged to choose activities/groups that they want to lead. Some groups are run by medical staff (at all levels), as well as by other staff who do not regularly work on the ward. In another trust, a service user representative regularly spends time with patients on the ward.

3. At another trust, the clinical pharmacist runs both group and individual medication concordance programmes.
Inpatients are cared for in a therapeutic, safe and sensitive environment.

- Single-sex areas are offered, as well as single bedrooms.
- Safe gardens with smoking areas are accessible to patients.
- There is plenty of space.
- Investment in inpatient services is maintained, despite bed reductions.
- An electronic prescribing system offers improved efficiency.

Observations

1. Some trusts have regular interface meetings with senior police officers as well as the local patch officer. These relationships are supported by agreed policies that cover issues such as violence and drug abuse.

2. We observed various models that ensure good working relationships between nurses in the three main environments: inpatient, day hospital and home treatment. These include rotation according to need, fixed rotations, shared offices and daily ward visits. In several trusts, these areas come under one management unit, and usually one manager.

3. One trust has invested in its own pharmacy service, with clinical pharmacists and technicians who are readily available to support and advise staff, patients and carers.
There is a joint commissioning strategy including health and social care and housing agencies, which includes the provision of a place to which patients can be moved.

There is an ongoing commitment to investing in inpatient care.

Observations

1. In some units, the demand for beds has been reduced due to the introduction of home treatment teams. As a result, wards are either becoming single-sex or are being restructured to provide single bedrooms.

2. As bed usage has been reduced in one trust, it has become possible to make more space available for activities and one-to-one sessions, avoiding the closure of wards.

3. Despite the reduction in bed use, one of the trusts we observed recognises that those patients using hospital beds still require good levels of staffing. As a result, any savings have been re-invested to maintain staffing levels, train staff, develop new roles (such as discharge liaison nurses) and run activities and groups.
**Measures for improvement**

<table>
<thead>
<tr>
<th>Alternatives to admission</th>
<th>Effectiveness of community support</th>
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<tr>
<td>The proportion of admissions to the crisis resolution team/home treatment team (CRHT), compared with admissions to inpatient care (ie. the percentage of admissions which are gate-kept by the CRHT. They should be 100% and are currently at 68% with 33% not involved at all).</td>
<td>The community survival rate (how well a patient copes outside the hospital setting).</td>
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<tr>
<td>The number of admissions for fewer than three days not seen by the crisis resolution team/home treatment team, compared with those patients who are seen.</td>
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**Effective targeting of resources**

- The proportion of admissions that show a pattern of increased service contacts prior to admission.
- The comparative use of resources by those on enhanced and standard care programme approaches.
- The number of admissions of clients previously unknown to the service.
- The number of admissions known to the service against readmission rate.

**Appropriate length of stay for acute inpatients**

- The mean length of stay, related to delayed transfer of care and availability of accommodation.
- The proportion of admissions that last longer than the pre-determined period of time.

**Service quality**

- The percentage of patients with a care plan.
- The results of patient satisfaction surveys on the management of patient expectations.
- The percentage of patients who are given a choice within the care package.
- The results of staff satisfaction surveys on multidisciplinary team working.
- The results of staff satisfaction surveys on aspects of the care pathway, in particular in relation to training and access to senior advice.
- Consultant/team data by:
  - diagnosis and length of stay
  - readmission rates within 28 days of discharge.
- The costs of inpatient care versus home treatment team care.
- Auditing clinical practices to identify areas that may not be reflecting agreed policies accurately.
Payment by Results

Payment by Results (PbR) details the NHS financial reforms that link payment to activity, adjusted for case mix. It has not yet been implemented in mental health services. The Department of Health outlined the following timetable for the PbR in mental health project in a factsheet issued in July 2006:

- Summer 2006: data collection, data quality improvements, analysis and sanity checks.
- October 2006: proposals and recommendations on next steps.
- January 2007: decision on next steps.

Twenty-two NHS mental health trusts are engaged in the PbR mental health project. Some form of grouping under PbR could become the funding mechanism for mental health services in the future. If so, mental health organisations will need to understand and optimise fully the services they deliver.

Although the data from the measures for improvement are not currently collected nationally, it is possible to collect local data through Hospital Episode Statistics and the Mental Health Minimum Data Set. In addition, benchmarking information is available through the work of Professor Gyles Glover at the University of Durham.3

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3 Professor Gyles Glover at the Centre for Public Mental Health, University of Durham (www.dur.ac.uk/mental.health/index.php?l1=3&l2=4&s=4)
Benefits

Delivering high quality care achieves a wide range of benefits for every sector of the NHS. Figure 3 illustrates that by delivering quality and value for acute adult mental health patients, a number of common benefits can be realised. These benefits apply to the following four dimensions of NHS care:

- Patient and service outcomes.
- Efficient delivery of services.
- Valuing staff.
- Delivering value for money.

Figure 3
Conclusion

Optimal delivery of high quality care for acute adult mental health patients is an achievable goal. The opportunities for quality improvement in this area are immense: improved outcomes for patients, supported by evidence-based delivery of services; reduced use of hospital beds; and increased patient, carer and staff satisfaction.

The contents of this report are based on the Delivering Quality and Value team’s observations of the practices of NHS organisations that are judged to be delivering high quality care and value for money. Although these observations have been tested thoroughly, it should be recognised that they may not be the only ways of delivering high quality care and value for money, but we believe that they will give valuable guidance and direction to those seeking this goal.

To improve services, organisations should follow this guidance and take the following simple steps:

- Understand how your organisation performs when compared against the key measures and benchmarks suggested.
- Generate a locally owned change programme for improvement.
- Integrate the local change management programme within health community integrated service improvement programmes (ISIPs) and local delivery plans (LDPs).

Further products will be produced to support implementation of this guidance and local improvement. In particular, the Delivering Quality and Value team expects to produce the following to support the acute admissions in adult mental health pathway:

- A website with the pathway measures, documents and resources for implementing the pathway.
- A hard copy pathway and principles discussion tool for use by staff and service users.

We would value your contributions to our future work. If you would like to be involved, or have any comments, please contact the Delivering Quality and Value team at HRG@institute.nhs.uk.
We wish to thank everyone who has contributed their time to enable us to carry out this work, and in particular the staff who took time out from their busy schedules to show us how they work and for all the information they shared. This includes the organisations we visited and their associated PCTs, mental health trusts and local authorities.

We are very grateful to the leaders of the mental health and social care trusts we worked with for agreeing to our visits, and we are grateful to those senior staff who organised our time so well and made us feel so welcome.

In several places, we had the added advantage of meeting with users and carers and their representatives, and we are also indebted to them.

The trusts we visited were:
- Derbyshire Partnership NHS Trust
- Lincolnshire Partnership NHS Trust
- Somerset Partnership NHS Trust
- Mater Hospital Trust, Belfast and North and East Belfast

We would also like to thank the following for their contribution:
We are grateful for the sponsorship and support we have received from CSIP and for the opportunities they have given us to link with others. In particular, we would like to thank the members of The National Acute Inpatient Mental Health Project Board for their interest and input. Without them, this work could not have been completed.
Further information
Published material


Organisations and online resources

Department of Health: Payment by Results

The Royal College of Psychiatrists’ Accreditation for Acute Inpatient Mental Health Services (AIMS) process:
(www.rcpsych.ac.uk/crtu/centreforqualityimprovement/aims.aspx).

Hospital Episode Statistics main specialty tables: