Healthcare Commission

The pathway to recovery

A review of NHS acute inpatient mental health services

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The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare. In this work, we collaborate closely with the Healthcare Inspectorate Wales, which is responsible for the NHS and independent healthcare in Wales.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.

- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.

- Be independent, fair and open in our decision making, and consultative about our processes.

Foreword

Professor Sir Ian Kennedy
Chair

People with complex mental health problems often also suffer from a loss of social and economic wellbeing, which in turn can lead to further problems. One of the serious challenges to society is how to recognise their individual needs and decide on the appropriate actions to meet them.

Wards in hospital for people with acute mental health problems continue to be a critical component of mental health services. They play a major part in supporting people during times of crisis, relapse and ill health. Over time, there has been increased success in avoiding admissions to hospital, as community-based services have developed. However, when people do need to go into hospital, it is essential that the services provided offer the very best care and treatment from a highly skilled and experienced workforce. This is not consistently the case.

Our review is the most comprehensive national assessment of acute inpatient care ever undertaken in this country. It has focused on the outcomes for people using these services and on benchmarking the quality and safety of the services provided. We have assessed the provision of acute inpatient services as part of a pathway of acute care – the journey that a person takes from initial referral to discharge. This is in keeping with the review of the NHS carried out by Lord Darzi, which emphasises the need to deliver high quality care along pathways of care that achieve the best possible outcomes for people.

There are some encouraging signs in our findings: a testament to the dedication and commitment of staff working in this field. It suggests that the renewed focus on acute care services, supported by a range of national initiatives, is helping to support progress in a positive direction. Among the best performers, the priority and direction given to acute

inpatient services, the skills and quality of staff and leaders, and the engagement of people who use the services and their carers have underpinned their success.

However, we have also found wide variation in the quality of services and in certain aspects of care and, in some instances, examples of unacceptable practices. In particular, more needs to be done to ensure that acute inpatient services are more personalised as a basis for promoting recovery, that they are provided in places where everyone is and feels safe, and that they provide the most appropriate range of interventions.

As acute care services form a significant element of expenditure on mental health services, we believe that the commissioning of these services is crucial to bringing about improvement. We also believe that those commissioning health and social care at a local level can use our findings to commission an effective, fully integrated pathway of acute care. We ask providers of services to use our results to inform development of services and practices, and to consider how they might use the range of national policy, guidance and tools to support this process.

It is important that our recommendations for improvement are considered in the context of a system-wide approach to improving quality and are clearly linked to other initiatives aimed at improvement.

We encourage involvement in initiatives for improving quality, and participation in national and regional networks. We urge the Department for Health to ensure that the new strategy for mental health takes account of the priorities that we have identified and the recommendations we have made.

Together, we can all build on the current service, to improve the pathway to recovery.

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 (BME) groups. We have particular concerns that the views of people from BME 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 BME 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 BME 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.

About the review

The importance of acute inpatient mental health services

A key aim of mental health care in England in recent years has been to support people to live more independent lives through better care and treatment in the community. Although this may have led to a more appropriate range of care choices for people who use mental health services, arguably it has also 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.

Inpatient wards continue to be an essential element in providing mental health services in the NHS and, of these, acute wards play a key role in addressing the needs of people with mental health problems during times of crisis, relapse and ill health.

Why conduct a review of NHS acute inpatient mental health services?

Over the last decade, a number of reports have highlighted concerns about the quality of provision of acute inpatient services with clear evidence of unmet needs.[1,2,3,4] 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.

In 2005/2006, we conducted a joint review, with the Commission for Social Care Inspection, of specialist community mental health services for adults of working age in England.[5] It found wide variations in the quality of services, and considerable scope for improvement in the fundamental areas of access to care and treatment, care management and support for recovery and social inclusion.

Our acute inpatient mental health service review provides a complementary follow-up to this, focusing on a key component of mental health service provision. It also builds on the work of other collaborative initiatives and work we have carried out in this area.

This review is the most comprehensive national assessment of NHS acute inpatient care ever undertaken in this country. It gives us the opportunity to assess the extent to which the policy objectives for acute care have been implemented, and to use the findings to highlight areas needing further improvement, particularly in relation to the interface between community and inpatient services. The review offers a framework that focuses on outcomes and the quality of services, on which future commissioning and performance management of acute care service can be based.

This is the first of two reports. The recommendations in this report are aimed at NHS providers of acute inpatient services, health and social care commissioners, and those responsible for assessing and monitoring performance, supporting improvement and developing policy.

The second report, due for publication later in 2008, will present our findings on the issues of most concern to people who use mental health services, and their carers. It will identify ways in which they can encourage improvement in local services.

Background and context

Mental health inpatient settings can be of different types, including:

- Acute psychiatric wards, sometimes also called acute admission wards.

- Psychiatric intensive care units (PICUs).

- Rehabilitation wards.

- Inpatient services that offer various levels of security (known as low secure, medium secure, and high secure services).

- Specialist inpatient services supporting people with particular needs, such as mother with babies, people with drug and alcohol problems and people with eating disorders.

In 2006/2007, inpatient services accounted for around a third of all direct NHS expenditure on mental health for working age adults.[6]* Around two-thirds (63%) of beds available for people with a mental illness were registered as serving adults aged 18 to 64. The largest proportion of these beds were for people needing a short stay in hospital (see table 1).

Despite the fact that the overall number of acute beds has gone down in recent years, acute wards continue to form the largest single element of expenditure on mental health inpatient services, in terms of both estates and staffing. In 2006/2007, the direct expenditure on acute inpatient services was £577 million and on PICUs was £103 million.[6] The average cost of acute psychiatric inpatient care for adults in 2006/2007 was £259 per bed day.[7]

Over the last two decades, the changes in the pattern of mental health service provision have meant that acute inpatient services have been used in a different way. In the period leading up to the 1990s, the number of NHS acute inpatient beds steadily decreased as a result of the closure of larger psychiatric hospitals. More recently, the number of acute psychiatric beds has continued to fall, with a drop of 4.7% in England between 1999 and 2003 to a level of 0.27 beds per 1,000 population.[8] However, there has been a rise in the proportion of inpatient beds provided by the independent sector, from 11% of the total in 2006 to 14% in 2007.[9]

Since the late 1990s, the rate of detentions under the Mental Health Act 1983 has levelled off at around 45,000 detentions per year. However, as the general rate of admissions has decreased, the ratio of detained to informal patients is now higher.[10] In 2007, detained

Table 1: Available beds by type of wards for adults of working age, NHS organisations in England, 2006/2007	
Type of ward (Department of Health categories)	Average daily number of beds available
Mental illness: other ages: short stay	11,761
Mental illness: other ages: long stay	2,887
Mental illness: other ages: secure unit	2,993
Total	**17,641**

Source: Department of Health form KH03

*This figure covers direct expenditure on acute inpatient units, secure and high dependency care. It does not include indirect costs, capital charges and overheads.

patients formed around 40% of all people admitted to acute admission wards.[9]

The success of community alternatives, such as support by a crisis resolution home treatment team, has been a key factor contributing to fewer acute admissions and a reduction in the number of occupied bed days.[11]

One consequence of this may be that service users are admitted to hospital at more acute stages of illness, perhaps evidenced by the relative increase in the proportion of detained patients. Hospital has come to be viewed as the care setting only for those with acute psychosis, and the treatment setting for those with complex needs, such as having a drug or alcohol problem alongside a mental illness.

Over time, the role of acute care services has become more defined, with an increasing emphasis on a crisis stabilisation function within the acute care pathway. This has been alongside the growing development of evidence-based interventions to promote recovery through the different stages of the pathway.

Standard 5 of the *National Service Framework for Mental Health* (NSF), published in 1999, clarified the expectations for people with mental health problems needing admission to hospital.[1] This included timely access to an appropriate bed in the least restrictive setting and as close to home as possible.

The Department of Health's *Mental health policy implementation guide for adult acute inpatient care provision,* published in 2002[2], and subsequent policy guidance, sought to encourage improvement and clarity of function in inpatient services. This included redefining inpatient services as part of an acute care pathway.

The five-year review of the NSF in 2004 highlighted the need for continued improvement in mental health inpatient services, particularly around adequate staffing levels, the management of dual diagnosis, creating a therapeutic environment and developing models of care, along with research to strengthen the evidence for effective inpatient care.[8]

Various national reports and studies have highlighted concerns about the quality of inpatient services, not least from the perspective of service users themselves.[12] This has also led to public concern about the safety of these services.

Key issues raised include:

- The failure to give the same priority to modernising acute inpatient services as other service components.

- The escalation of bed occupancy rates in some areas, leading to overcrowding and service users 'sleeping out', being admitted to hospital long distances from home or being discharged before they are ready.

- Inadequate accommodation or support that delays discharge from hospital, reflecting the lack of understanding or focus on integrated commissioning of acute care services.

- Ongoing concerns about the levels of violence or aggression in inpatient units.

- The lack of a positive therapeutic environment or sufficient activities for inpatients, especially during the evenings and at weekends.

- Lack of regular, skilled staff of all levels on acute wards, which can compromise therapeutic effectiveness and safety.

- Lack of commissioning focus, poor resourcing, slow modernisation, and

inadequate environments that do not promote privacy, dignity and safety.

- Services not meeting the needs of certain groups, for example people from black and minority ethnic (BME) groups or people with a dual diagnosis.

In response to these concerns, a National Acute Mental Health Project board was established in 2005 as a formal partnership between the Care Services Improvement Partnership-National Institute for Mental Health in England (CSIP-NIMHE) acute programme, the Department of Health and the National Mental Health Partnership (subsequently the NHS Confederation mental health network). Its core purpose is to provide a collective approach between key stakeholders to achieve more rapid delivery of acute mental health policy, redesign of services, and better health and social outcomes for acute care service users.

Over the last three years, this board has coordinated a range of initiatives to improve the quality of acute service provision, including:

- Providing expert advice to help develop the assessment framework underpinning this service review.

- Developing a good practice handbook, *Onwards and Upwards*, to accompany the review.[13]

- Developing proposals for a national accreditation scheme for the management of violence.

- Launching the *Virtual Ward* website to promote an easy exchange of positive acute practice for staff and the public.[14]

- Sponsoring and supporting the launch of *Star Wards*, an initiative led by a service user to improve the daily experiences and

outcomes for people in mental health inpatient wards.[15]

- Acting as an expert reference group for the value for money audit on crisis resolution and home treatment services, carried out by the National Audit Office.[11]

- Publishing *A positive outlook*, a discharge toolkit publication, in partnership with the older adult programme.[16]

- Commissioning North East London Mental Health NHS Trust to produce *STEPS*, a positive practice handbook about successful team management in inpatient psychiatric services.[17]

- Commissioning the development of the *Strategies to Reduce Missing Patients* in partnership with the Suicide Prevention programme, due for publication in summer 2008.

- Commissioning the development of *Informed Gender Practice – mental health acute care that works for women* in partnership with the Equality, Race and Gender programme.[18]

- Publishing *Laying the Foundations,* a practical service redesign and capital investment workbook.[19]

- Developing the *Not just staffing numbers* acute workforce redesign workbook, due to be published in summer 2008.

These last two publications have been developed to assist the action planning arising from this review.

Our service review has been developed in consultation with members of this board to ensure that it has strong links with other national initiatives around acute inpatient care. The standards subgroup of this board has

steered the detailed work to develop the assessment.

In addition to representatives from the CSIP-NIMHE acute care programme and National Acute Mental Health Project, this subgroup included colleagues from the Mental Health Act Commission and the Royal College of Psychiatrists' Centre for Quality Improvement. This group has ensured that the standards framework underpinning our assessment has been aligned with that developed by the Centre for Quality Improvement for its Accreditation of Acute Inpatient Mental Health Services (AIMS) initiative.

This review complements and builds on other collaborative work we have carried out, including:

- *Count me in* census, a joint initiative between the Healthcare Commission, the Mental Health Act Commission (MHAC) and CSIP-NIMHE.[9] Since 2005, this census has collected robust figures at the end of March each year on inpatients in mental health and learning disability hospitals in England and Wales. The aim is to encourage providers to record inpatients' ethnicity accurately and collect information that will help providers to take practical steps to achieve the Government's five-year plan, Delivering Race Equality in Mental Health Care.

- *National Audit of Violence*, a national study conducted for the Healthcare Commission by the Royal College of Psychiatrists, in 2003 to 2005[20] and then 2006/2007.[21] The initial findings from this study highlighted the levels of violence in mental health and learning disability services, the causes of incidents and areas of best practice as well as recommendations for practice development. The second audit reported

significant improvements, but identified areas for continued focus.

- *Talking about medicines*, the report of a review into medicines management within mental health trusts which included the development of a leadership learning set to improve safety in prescribing and administration on acute wards.[22]

- Work with other regulatory bodies to develop their review of performance, in liaison with other independent agencies to develop standards-based assessments and to strengthen our core assessment in relation to assurance against acute care policies. Examples include: supporting the development of the patient environment action team (PEAT) framework for improving environment for mental health and healthy lifestyle initiatives; supporting the development of the Prescribing Observatory for Mental Health (POMH-UK) standards and the Royal College of Psychiatrists' AIMS peer review standards; and collaboration with the NHS Litigation Authority (NHSLA) to develop improved standards around rapid tranquillisation and resuscitation.

Other regulatory bodies also assess aspects of the performance of inpatient services on an ongoing basis and we have used their assessments wherever possible within our review. These include:

- MHAC, which has a programme for visiting mental health hospitals, to review the operation of the Mental Health Act 1983 as it relates to detained patients and to provide safeguards to patients who lack the capacity to consent to treatment or who refuse consent.

- NHSLA, a special health authority responsible for handling clinical negligence

claims made against NHS bodies in England. Its role includes administration of the clinical negligence scheme for trusts (CNST) and the risk pooling scheme for trusts. Under CNST, healthcare organisations are regularly assessed against clinical risk management standards specifically developed to reflect issues that arise in the negligence claims reported to the NHSLA.

- The National Patient Safety Agency (NPSA), which leads and contributes to improved, safer patient care by informing, supporting and influencing healthcare organisations and individuals working in the health sector. Since 2005, NPSA has managed the PEAT programme, which provides an annual assessment of all inpatient healthcare facilities in England with more than 10 beds.

The scope of the review

This review has focused on NHS providers of acute mental health wards and psychiatric intensive care units that serve adults of working age.

The purpose of an acute ward is to provide "a high standard of humane treatment in a safe and therapeutic care setting for service users in the most vulnerable stage of their illness".[2] Psychiatric intensive care is "for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed phase of serious mental disorder".[3]

Other types of inpatient unit, such as rehabilitation, secure and specialist services, have not been included because the care

pathway for these services is different, as are the needs of people using these services.

We recognise that some services that have fallen within the scope of this review work with people regardless of their age. We have not included acute inpatient services that work primarily with adults aged 65 and above, because we are conducting a wider national study into services for older adults with mental health problems. We also decided not to include independent sector services, as different standards apply to these services and the care pathway in and out of these units can be different. However, aspects of the assessment framework could be usefully adapted for use by other services.

We assessed 69 mental health trusts* that were providing acute inpatient services at the time of the review. These trusts registered a total of 554 wards, providing 9,885 beds that fell within the scope of this assessment (out of over 11,000 beds nationally, see table 1 on page 14). This represents around half of all NHS beds for adults with mental health problems in England and 84% of beds registered with the Department of Health as available for providing short stay admissions at September 2007.**

The assessment framework

The content of the final assessment framework was informed by an extensive scoping exercise, consultation and pilot. We worked with 10 mental health trusts to test the draft framework, to evaluate the data collection process and the extent to which the assessment reflected the provision of local services.

* Around a fifth of the trusts we assessed were PCTs and five were care trusts. However, for simplicity, we use the team "mental health trust" throughout this report where appropriate.

** The remaining 16% are likely to be specialist services that were not included in the scope of the review or reflect the closure of wards between the period of data collection (June to August 2007) and the Department of Health snapshot based on service provision at the end of September 2007.

We consulted on the framework with the public, service users and carers, service providers, national and local organisations and other experts to assess its structure and coverage, the validity of the proposed indicators and the robustness of the data sources suggested.

The focus of the review

We set out to assess the quality and safety of acute inpatient mental health services within the acute care pathway. Our intention was to see how well healthcare providers and their partners have responded to the changing agenda around inpatient care, and to help services to benchmark their performance against national standards.

The overall focus was on assessing whether admissions to inpatient mental health services are appropriate, purposeful, therapeutic and safe. We used four criteria to see whether:

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.

Each of the four criteria consisted of a series of questions against which we have assessed performance. For each of the questions, there were one or more indicators. Appendix A outlines the framework of assessment, showing its general structure.

The assessment framework was not intended to cover all issues relating to acute inpatient care. We selected indicators on the basis that they reflected aspects of mental health inpatient services that are most important in improving outcomes, areas where there is most evidence of variation and where there may be non-compliance. The emphasis within the review has been on measuring the developmental aspects of acute inpatient services and those issues that reflect the outcomes for people using these services and the quality and safety of service provided.

We used existing national data and carried out a specific data collection to provide the information for our assessment. Further information about the data collection stage can be found in appendix B.

All mental health trusts that took part in the review were given a score as part of our annual health check for 2006/2007. The scoring system for the review was designed to give a simple overall assessment, based on the aggregation of results at indicator, question and criterion level, as follows:

- **Excellent** – this means that the performance of this trust goes well beyond the minimum requirements and the reasonable expectations of patients and the public.

- **Good** – this means that the performance of this trust goes beyond the minimum requirements and the reasonable expectations of patients and the public.

- **Fair** – this means that the performance of this trust only meets the minimum requirements and the reasonable expectations of patients and the public.

- **Weak** – this means that the performance of this trust does not meet the minimum requirements and the reasonable expectations of patients and the public.

We used all but one of the 59 published indicators to score trusts.* Of the remaining 58 indicators, we scored 47 against absolute thresholds, where the result for each trust was compared to a particular standard or level and 11 using relative methods, where results for trusts were compared to each other. We set all of the absolute thresholds in consultation with members of our steering group and other national experts.

All the indicators were equally weighted, with the exception of the indicator on whether service users' views were recorded on their most recent care plan. This was given more weight to reflect the importance of involving service users in care planning. Trusts who were scored weak for the indicator automatically received a score of weak for the related question on involving service users and carers in decisions about care and treatment.

The plan improvement stage

We have almost completed follow-up visits to 11 mental health trusts whose performance was identified as weaker on this assessment. The purpose of these 'plan improvement' visits is to review the areas where the trust performed less well within the service review, to clarify the underlying reasons for this, and to identify areas for improvement to be taken forward in an action plan.

The visit process builds on what was already known, supplemented by additional evidence, to increase the depth of understanding of local delivery or performance. We are working with these trusts to identify their strengths and

areas of development to enable them to develop their action plans.

All of the visits involve a lead assessor from the Healthcare Commission and a service user consultant. Most of the visits have also been attended by a representative from the CSIP-NIMHE Acute Mental Health Programme, who acted in an advisory role and to provide ongoing developmental advice and support to trusts after the team visit as required, in order to assist them in the delivery of their service improvement plan.

Success factors event

In January 2008, we invited representatives from some of the mental health trusts that had performed well in this review to a seminar to help us identify the features of their organisation or approaches that supported the development of high quality services. In addition to the feedback from the plan improvement visits, the event helped us to identify some of the challenges and obstacles to developing effective services.

We have summarised the key factors identified as supporting and hindering the development of high quality acute care services. These can be found in the later section of this report on "what makes the difference".

Further information

To find out more about how we developed the review, or for full details of the assessment framework, the data used and the services that were registered for the review, please visit our website at:

www.healthcarecommission.org.uk/acuteinpatientmentalhealthservicereview

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* The indicator on reviewing acute care services at trusts' board meetings was removed from the scoring model due to concerns about the quality of the data.

Overall results

The overall results for the 69 mental health trusts were as follows:

- 8 trusts (12%) were scored "excellent".

- 20 trusts (29%) were scored "good".

- 30 trusts (43%) were scored "fair".

- 11 trusts (16%) were scored "weak".

This means that two-fifths of trusts exceeded the minimum level of service provision, whereas less than a fifth failed to reach it. While this suggests that improvement is needed, these findings show that good quality acute inpatient services can be achieved.

However, no trusts were scored excellent on all four of the key criteria against which we assessed performance. This suggests that, nationally, there is room for improvement to ensure that service users can access a high quality of acute care services, even among trusts with a score of excellent or good.

Comparing the results from the joint review of community mental health services carried out in 2006/2007 and the results from this review:

- The same proportion of provider trusts were scored excellent on both reviews, but a higher proportion were scored weak for the quality of their inpatient services.

- Similar proportions were scored fair on both reviews, but 10% fewer trusts were given a score of good on this review.

- Two-thirds of trusts were scored the same or one score different.

Figure 1: Distribution of overall review scores for 69 trusts

Legend:
- Excellent
- Good
- Fair
- Weak

Pie chart values:
- 8 (12%)
- 20 (29%)
- 30 (43%)
- 11 (16%)
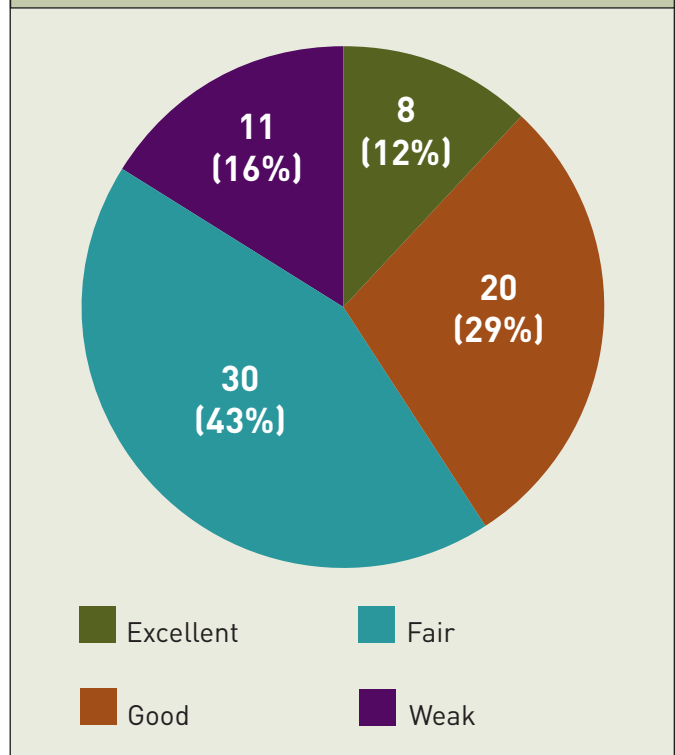
Table 2: Distribution of results by type of trust					
Type of trust	Number of trusts	Number of trusts scored "weak"	Number of trusts scored "fair"	Number of trusts scored "good"	Number of trusts scored "excellent"
Foundation trust*	15	0	5	6	4
Primary care trust	14	2	5	3	4
Mental health trust	35	7	18	10	0
Care trust	5	2	2	1	0
Total	**69**	**11**	**30**	**20**	**8**

* This refers to trusts that had foundation trust status at the time of conducting the review.

Analysis of scores by type of trust

There were some variations in performance between different types of trust (see table 2). Overall, the trusts that had become foundation trusts at the time we conducted the review performed better than other trust types. Half of those trusts that were scored excellent were foundation trusts and none of the foundation trusts was scored weak. However, the results were more varied for those trusts that achieved foundation trust status later on and those applying to become foundation trusts.

The results for primary care trust (PCT) providers of acute inpatient services were spread across the four bands, although more were scored excellent* than weak. None of the other types of mental health trust were scored excellent.

Analysis by strategic health authority

Some regional variations were also apparent (see table 3). The strategic health authority (SHA) in the West Midlands had the highest proportion of trusts that were scored excellent, followed by Yorkshire and Humber. London, North West, West Midlands, and Yorkshire and Humber SHAs all had two trusts that were scored weak within their area, but no SHA had more than two.

There were some SHAs where the performance of trusts grouped around the middle two scoring bands. All the trusts in the East of England and South East Coast SHAs were scored either good or fair. None of these trusts (along with those in East Midlands, North East and North West SHAs) were scored excellent, suggesting there is scope for improvement in these areas.

* In absolute numbers, this was the same as for foundation trusts.

Table 3: Distribution of results by strategic health authority					
Strategic health authority	Number of trusts	% of trusts scored "weak"	% of trusts scored "fair"	% of trusts scored "good"	% of trusts scored "excellent"
East Midlands	5	20%	20%	60%	0%
East of England	7	0%	71%	29%	0%
London	9	22%	44%	22%	11%
North East	2	50%	0%	50%	0%
North West	8	25%	50%	25%	0%
South Central	6	0%	17%	67%	17%
South East Coast	3	0%	67%	33%	0%
South West	8	13%	50%	25%	13%
West Midlands	11	18%	55%	0%	27%
Yorkshire and Humber	10	20%	30%	30%	20%
Total	**69**	**16%**	**43%**	**29%**	**12%**

Analysis by other variables

We also looked at the overall results in relation to other variables, although the number of trusts limited the extent of statistical tests we could apply to our analysis. There were no differences in the distribution of overall scores in relation to the proportion of inpatients from black and minority ethnic (BME) groups. We did find some significant differences in relation to certain indicators, which we explore later (see "support for people from black and minority ethnic groups" on page 31).

We reviewed the results in relation to the number of wards and, more specifically, the number of acute inpatient beds that trusts had at the time. Six of the eight trusts that were scored excellent had less than 100 beds and were operating five wards or fewer, and nine of the 11 trusts that were scored weak were

providing more than 100 beds. Moreover, 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%) (see table 4 overleaf). This does suggest that the larger the trust, the greater the challenge in achieving consistent standards across all wards.

Lastly, we devised an index for the level of deprivation for each trust, based on the postcodes of service users admitted to mental health hospitals during 2006/2007, and another index on whether people admitted to these hospitals came from an urban or rural area. There were no differences in relation to the proportion of trusts that were scored excellent, good or fair. However, the trusts that were scored weak were more likely to be serving an urban, more deprived population. Table 5 overleaf illustrates these findings.

Table 4: Breakdown of beds and wards by overall review score				
Overall score	Number of beds	Percentage of beds	Number of wards	Percentage of wards
Weak	2,249	23%	131	24%
Fair	3,985	40%	224	40%
Good	2,808	28%	154	28%
Excellent	843	9%	45	8%
Total	9,885	100%	554	100%

Table 5: Analysis of scores by deprivation* and urban/rural ** indices					
Score	Total number of trusts	Percentage of trusts with a lower deprivation score	Percentage of trusts with a higher deprivation score	Percentage of trusts serving more rural populations	Percentage of trusts serving more urban populations
Excellent	8	50%	50%	50%	50%
Good	20	60%	40%	60%	40%
Fair	30	50%	50%	53%	47%
Weak	11	36%	64%	27%	73%

* To generate deprivation scores, we used the Index of Multiple Deprivation 2007 and assigned each person admitted to hospital the relevant deprivation score for their postcode. We then derived a score for each trust by averaging all those admitted during the year.

** For the urban/rural index, we used the urban/rural indicator flag in the Gridlink NHS Postcode file from the Office for National Statistics. An urban flag was applied if the person's postcode was within a settlement of 10,000 or more. All other postcodes were assigned as rural.

Analysis by the key criteria

In relation to the four key criteria in the assessment, the highest proportion of trusts – just under two-fifths – were scored weak on the criterion that assessed involving service users and carers (see table 6). Around another quarter were scored fair. However, this was also the criterion with the highest proportion of trusts scoring excellent. In fact, all of the trusts that were scored excellent overall, were scored excellent for this criterion. And all of the trusts that were scored weak overall, were scored weak for this criterion.

For the other key criteria:

- Around one in every nine trusts was scored weak on the criteria for providing individualised care and for ensuring safety.

- Just over two-fifths of trusts were scored fair for whole person care and around half of trusts were scored fair for the criterion on ensuring safety.

Table 6: Criteria-level results				
	Proportion of 69 mental health trusts that were scored:			
Criteria	Weak	Fair	Good	Excellent
1: Effective care pathway	7%	52%	41%	0%
2: Individualised whole person care	12%	43%	35%	10%
3: Involvement of service users and carers	39%	26%	20%	15%
4: Safety	12%	52%	32%	4%

- No trusts were scored excellent for the effectiveness of the care pathway, although fewer trusts were scored weak for this criterion compared with the other three criteria, with a grouping of the results around the middle two bands.

All 69 mental health trusts received a detailed assessment of their acute inpatient services. The final results were circulated in June 2008 and these are available, for each trust, on our website. Appendix C shows how trusts performed overall against each question in the assessment.

Detailed findings

During the review, there were six key themes that emerged from our analysis:

- Focusing on the individual and personalising care

- Ensuring the safety of service users, visitors and staff

- Providing appropriate and safe interventions

- Increasing the effectiveness of the acute care pathway

- Workforce development

- Strategic management and operational development of acute care services.

Our key findings are set out in the following chapters under these headings. Note that, as a result, the headings do not directly correspond to the four criteria against which we assessed trusts.

Focusing on the individual and personalising care

> "Involvement is tokenistic: the ward staff present you with a care plan and ask you to sign it. It is explained to you but you are not involved in the planning."
>
> **Service user interviewed during a plan improvement visit**

In our *State of Healthcare 2007* report, we highlighted the general need for more sensitivity to the needs of individuals.[23] This chapter presents relevant findings from this review and reinforces the need for further action to ensure that care and treatment are personalised.

Involving and engaging service users

Involving service users in planning their care
Actively involving service users in planning, developing and reviewing their care and treatment is a principle that is enshrined in mental health policy – it is important to their recovery.[24,25,26] Most people who receive inpatient care are not detained under the Mental Health Act and are therefore 'informal' patients – and so are under no legal compulsion to accept care and treatment. Even when inpatients are detained under the Mental Health Act, and therefore subject to such compulsion, the starting point is to provide them with opportunities to be involved.[27]

Those responsible for delivering care and treatment in mental health services need to balance care and control with sensitivity and, in all situations, ensure that the human rights of individuals are upheld. The Department of Health's *Policy implementation guidance for adult acute inpatient care provision* says that inpatient care is a time when service users

must have their needs specifically planned for.[2] Service users should be given a copy of their care plan, which should record their views and which they should be invited to sign.[24, 25]

Our review raises particular concerns about how effectively service users are being involved in planning their own care. In a sample of care records, only half had service user views recorded on the most recent care plan. Although there were some trusts where the views of service users were recorded in all the care plans that we audited, in one trust only 2% of care plans included their views (see figure 2).

Fifty-five per cent of trusts were scored "weak" for this indicator. Of all the 58 indicators in the assessment, this one alone was given more weight. Trusts who were scored "weak" for this indicator automatically received a score of weak for the related question on service user and carer involvement in decisions about care and treatment. This affected the scores of 38 out of the 69 trusts for this question.

While the majority of trusts were scored weak for recording service users' views on their most recent care plan, the results from the best performing services show that this can be achieved consistently for all service users.

Service users interviewed as part of the plan improvement visits often reported not feeling sufficiently involved in planning their own care. This included not feeling consulted, listened to or feeling involved in making decisions, and not being given a copy or being asked to sign their care plans. While some care planning forms did not provide space for service users to record their views, the evidence suggested that, more significantly, there was inadequate or inconsistent practice in engaging service users in this process.

"Making the difficult journey to becoming better is only achieved when the individual service user is enabled to be at the centre of their care and treatment, through care planning. Even when users are extremely unwell, the art of true mental health intervention is to hold the hope of recovery for that individual, then gradually give it back so that the service user can take more control and make choices over their own lives – whatever the situation they find themselves in. It is completely unacceptable that service users are not involved in their care planning, at whatever level. Recovery only happens then in spite of service delivery and not as a partnership between those requiring help and those supposedly giving it."

Service user and Healthcare Commission associate

One-to-one time with staff

Feedback from service users has shown that more one-to-one contact with staff would make the biggest difference to their experience of acute inpatient mental heath wards.[28] Research has indicated that the amount of meaningful time nurses have spent with patients has been limited.[29]

Protected therapeutic engagement time between mental health nurses and service users is recommended in national policy[30], and has been implemented on some wards to ensure that service users have one-to-one time with staff.

We asked about the number of days during the first week of admission on which a member of nursing staff and a service user spent at least 15 minutes together over the course of one shift. Our findings highlighted a stark variation in the frequency with which this happened, with a similar proportion reported for no days and every day during this first week (see figure 3 overleaf).

Figure 2: Views of service users recorded on their most recent care plan for 69 trusts
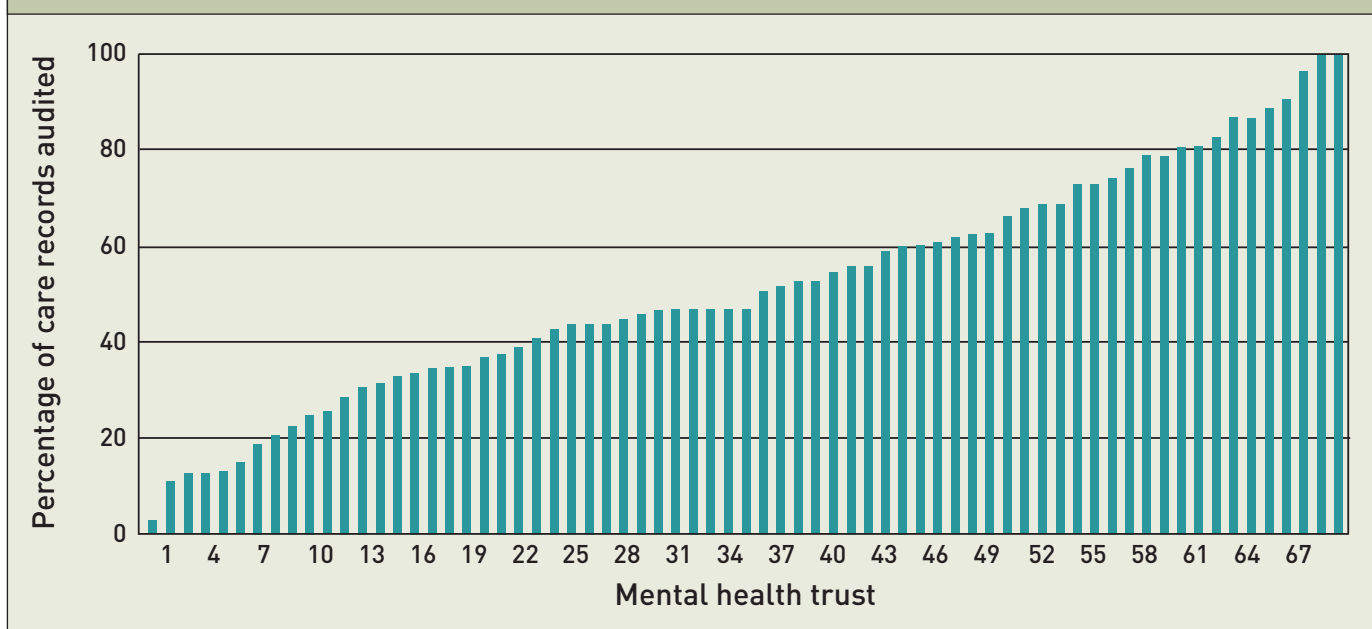
Figure 3: Number of days on which service users received at least one one-to-one session in the first seven days of admission
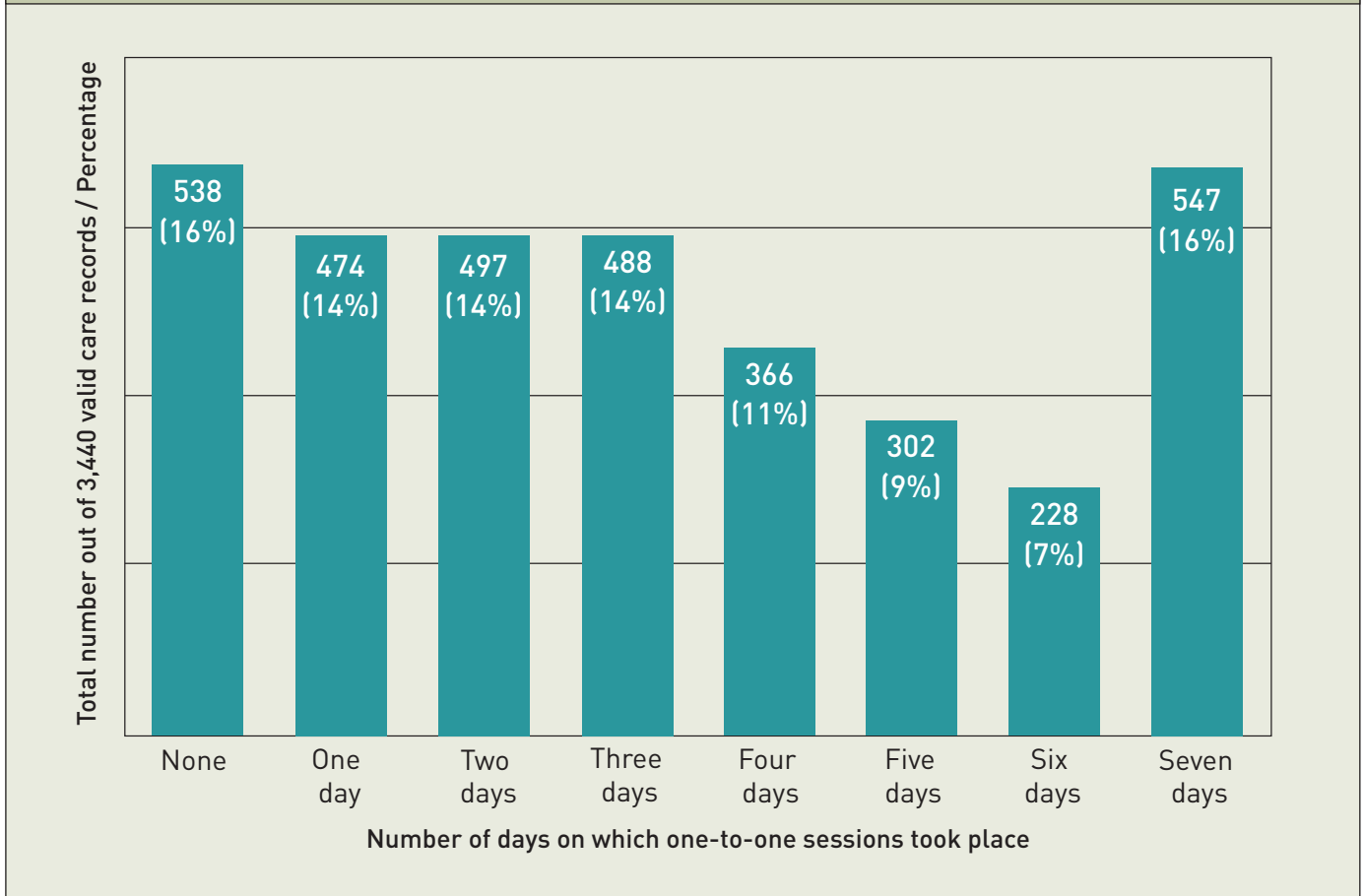
These results agree with the findings from the *2006/2007 National Audit of Violence* for working age adults on acute wards. When service users were asked whether they were able to speak to staff when they needed to, 12% answered "no".[21]

Involving carers

The involvement of carers, family members and others who have an interest in a person's welfare should be encouraged.[27]

The first step to involving a carer is to identify if there is one. We found that just under a third (30%) of cases sampled did not record whether or not there was a carer. Although in some trusts, this was achieved in all the care records we sampled, at the lowest, only 16% of care records identified if there was a carer. Our review also highlighted the need for trusts to develop their structures to promote carer involvement.

National guidance recommends that clear admission and assessment protocols are developed and described so that:

- An interview is offered within three working days of admission with a named ward carer worker.

- The carer's views about ongoing and future involvement are recorded.

- Carers are given an information sheet describing local arrangements.

- Carers are offered a referral to a carer support worker.

- Carers are provided with a carer's pack by staff or the carer support worker.[31]

Staff who undertake assessment and care planning should have received training in how to involve patients and carers.[32] Education and training that increases awareness of patients' and carers' individual needs should be available for all healthcare personnel.[32]

Although we recognise that it is a matter of local discretion as to how best to ensure carer involvement, our review found that nationally:

- Only 32% of front line ward staff had been trained in supporting carers and families, although this ranged from all ward staff having been trained to none.

- 40% of wards had a carer lead, which we defined as a dedicated staff member responsible for leading on carer issues – including overseeing and developing strategies to support carers at ward level.

- Most trusts had either opted for staff training or appointed a carer lead, but not both.

- Around two-thirds of wards had a directory of carer support organisations, information sources and resources. But on only just over half of wards were there packs for carers that contained information about their rights to a carer's assessment, or information about how to access carer support workers.

Information for service users and carers

There is a wealth of national guidance and best practice on the types of information that should be given to service users and carers. Much of this recommends that service users should be given a welcome pack or introductory document when they are admitted, or as soon as they are well enough to take in this information.[33, 34, 35, 36]

For service users from black and minority ethnic (BME) groups, good information also has the potential to increase confidence in statutory services. Increasing confidence in this respect has been identified by the NHS management board as a priority and is a key objective of the Delivering Race Equality programme.

Information for carers should be available on the ward and elsewhere in the hospital.[2, 28]

We asked service user representatives to check the availability and content of welcome packs on every ward included in the review. We found that:

- The vast majority of wards had a welcome pack for service users, although 24 wards from 13 trusts had none of the information we asked about for service users at all.

- Information packs for carers were more scarce and performance was very variable – although about a third of all wards (32%) had a welcome pack for carers containing all of the information we asked about, one in five wards had none of this information available (21%).

The representatives also reported that half of all wards did not have an up-to-date photo board of ward staff prominently displayed. Feedback from the plan improvement visits also showed that staff did not regularly wear name badges in accordance with their trust's policy or did not wear them where they were visible.

Explanation of rights for detained patients

Providers are required by law to provide information to detained patients, and their nearest relative, unless the person objects. Section 132 of the Mental Health Act 1983 places a duty on the hospital managers to ensure that every detained patient understands their legal status and rights. The *Mental Health Act code of practice* has guidance on how this should be done.[27] Information should be given at a suitable time and in a way that is understandable, and regular checks should be made to ensure that this has been conveyed and taken in.

Article 5(2) of the European convention on human rights arguably places a wider obligation on providers than section 132, in that it requires patients to be notified of the reasons for their detention (not merely the consequences of being detained), the statutory authority for that detention, and the ways in which they can challenge it.

As part of the programme of ward visiting, the Mental Health Act Commission (MHAC) checks a sample of care records of detained patients. These checks indicated that, of 6,705 case notes, there was no formal record in 10% of cases that service users had had their rights explained to them. This ranged between trusts from 30% to 100% of the case notes of detained patients checked.

Although four out of five wards (80%) had a welcome pack for service users that contained information on their rights under the Mental Health Act 1983, only about half of all wards (53%) had information packs for carers that contained information on the rights of the nearest relative.

Accessibility of information

Our findings were more positive for providing information in different languages (see table 7). However, the results indicated that information for both service users and carers could be made far more accessible. In particular, the poorest results related to information for people with a sensory impairment, people with a learning disability and in age appropriate formats (of particular relevance to young carers).

Identifying and meeting the needs of groups with diverse needs

When we developed the review, we conducted a full equality impact assessment. We included indicators that would give us a picture about how well services were meeting the needs of groups with diverse needs, in particular:

- Support for people from BME groups.

- Access to specialist help for older people, younger people and people with a learning disability admitted to acute mental health wards for adults of working age.

- Facilities for people with a disability.

We included a specific question on providing care and support that was appropriate to individual needs that particularly included these issues. Over half of trusts (54%) were scored "fair" on this question with a further two-fifths (42%) achieving a rating of "good". However, only one trust achieved a score of "excellent" and two were scored "weak".

In our 2005/2006 review of community mental health services, we reported that only 32% of specialist mental health staff had received training in diversity awareness since they started work for their employer. For this review, we raised the bar and assessed trusts on the proportion of staff who had received training in

Table 7: Percentage of 554 wards reporting that information was available in a range of formats		
	For service users	**For carers**
Languages other than English	69%	60%
Simple language formats	67%	61%
Large print	64%	60%
Age-appropriate formats	55%	48%
Braille or spoken formats	51%	48%
Formats suitable for people with learning disabilities	51%	46%

at least two types of diversity training from their employer at any time. This showed a positive improvement on the findings of the community review – 48% of staff confirmed receiving this training. Although the differences between trusts were similar in range (26% to 68% of staff), the findings represent an improvement.

Support for people from black and minority ethnic groups
Higher proportions of people from black and minority ethnic groups are admitted to mental health hospitals and detained under the Mental Health Act.[10] National policy recommendations for BME service users include:

- Recording and monitoring ethnicity data.

- Providing access to interpreters where needed, to ensure that care is assessed, planned, delivered and evaluated effectively.

- Ensuring that information is available in different languages and formats.

- Ensuring that inpatients are able to have their spiritual and religious needs met.

- Access to worship space, faith leaders, and religious and faith groups.[34]

Our review found that:

- The quality of coding of ethnicity data has improved.

- 94% of ward managers confirmed that, if required, interpreters were provided "all of the time" or '"most of the time" for care review meetings, although this dropped to about two-thirds to enable service users to take part in ward-based meetings (68%) and to engage in therapies (63%) and activities (59%).

- 40% of the care records for people from BME groups contained an assessment of service users' spiritual needs and 41% contained an assessment of their cultural needs. Although still relatively low, the assessment of cultural needs was significantly more likely to have been recorded for service users from BME groups than for White British groups. For all service users, only 32% of care records contained an assessment of both spiritual and cultural needs.

- 94% of ward managers said that service users had access to pastoral and spiritual support that was appropriate to their needs "all of the time" or "most of the time".

These findings suggest that assessment processes need to be strengthened to ensure that spiritual and cultural needs are routinely assessed and recorded, and that access to interpreters should be extended to include a wider range of interventions and activities. Although the findings about access to pastoral and spiritual support are encouraging, unless needs are effectively assessed, it is difficult to determine how appropriate this support is. We also found that some trusts did well in relation to assessing spiritual and cultural needs, but then offered limited or no access to staff to meet these needs, and vice versa.

Figure 4: Percentage of care records where the service user's views were recorded on their most recent care plan by ethnicity
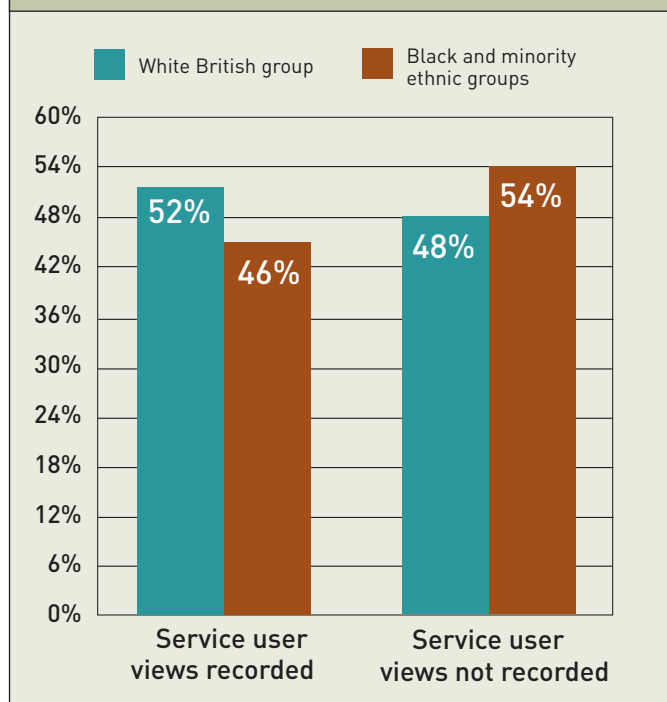
Of particular concern, our analysis showed that the care records for people from BME groups were significantly less likely to contain their views (46%) compared with White British service users (52%) (see figure 4).

There was also a significant difference in the results for service users having one-to-one sessions with staff during their first week of admission when analysed by ethnicity (see table 8):

- The proportion of service users that had not had a one-to-one session on any day during their first week of admission was significantly higher for people from BME groups (23% of service users from BME groups compared with 13% of White British people).

- The proportion of service users that had a one-to-one session every day during their first week of admission was significantly lower for people from BME groups (12% of service users from BME groups compared to 17% of White British people).

Support to meet individual needs
National policy recognises that there are occasions when service users with particular needs are admitted to acute wards because it is the most pragmatic decision clinically, or it is the most appropriate option available. In these instances, access to specialist support and advice is often recommended as a means of ensuring that the service can be tailored to best meet individual needs.

- Currently, admission of people under the age of 18 to an adult unit should only happen if there is access to child and adolescent psychiatric consultation and advice throughout admission.[36, 37] The amended Mental Health Act states that

detained patients under the age of 18 should not be admitted to an adult ward unless it is in exceptional circumstances.[38] Under the Operating Framework for the NHS in England 2008/2009, PCTs are asked to ensure that, by 2010, no 16 and 17-year olds are treated on adult psychiatric wards, unless such an admission is in accordance with their needs.[39]
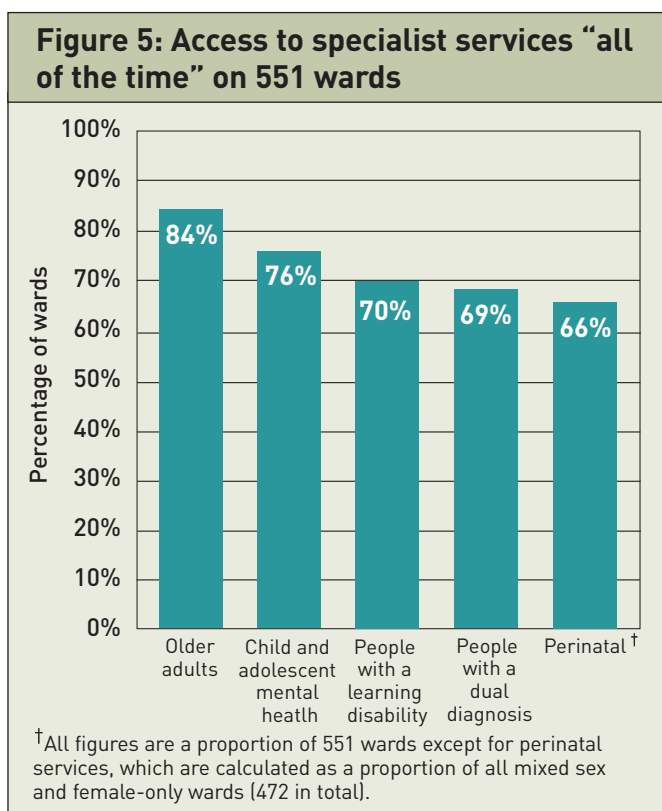
- There should be named consultant psychiatrist leads from both mental health and learning disability services for each inpatient unit.[40]

- Access to specialist support should be available to: people with dual diagnosis, older people's mental health services, and perinatal care.[41, 42, 43]

Our review assessed the proportion of wards with access to such specialist support. Generally this showed positive results, with at least two-thirds of wards saying they had access to specialist advice and support "all of the time" for these five groups. Wards were least likely to report this level of access in relation to perinatal and dual diagnosis services (see figure 5 overleaf).

Patient environment action teams (PEATs) assess facilities for people with disabilities. We drew on this to assess trusts' performance in relation to the facilities provided for people with a disability. We gave just under a third of trusts (29%) an "excellent" rating for their facilities, while another half (54%) had met the majority of the requirements.

Number of days on which one-to-one sessions took place	White British group		Black and minority ethnic groups		Total number of valid care records
	Number of valid care records	% of valid care records	Number of valid care records	% of valid care records	
0	359	13%	162	23%	521
1	368	14%	102	15%	470
2	392	15%	98	14%	490
3	372	14%	108	15%	480
4	288	11%	68	10%	356
5	259	10%	38	5%	297
6	185	7%	38	5%	223
7	445	17%	87	12%	532
Totals	2,668	100%	701	100%	3,369

Table 8: Number of days on which service users received at least one one-to-one session in the first seven days of admission by ethnicity

Figure 5: Access to specialist services "all of the time" on 551 wards

†All figures are a proportion of 551 wards except for perinatal services, which are calculated as a proportion of all mixed sex and female-only wards (472 in total).

Promoting social inclusion

A stigma is still attached to mental illness, and negative attitudes towards people with mental health problems often lead to fear and exclusion.[44] *

Boundaries between professions limit the care that patients can receive and boundaries between conventional services and the voluntary and private sectors often limit patient choice.[45]

It is when people are acutely unwell and admitted as inpatients that key aspects of their social inclusion may be most at risk. Admission as an inpatient can limit or preclude people from certain civic roles and has been linked to unemployment, homelessness, debt, and social isolation.[10, 46]

While in hospital, people can become isolated from their social networks and distanced from everyday life. Service providers should be sensitive to the impact of hospital admission on the individual and their family and carers.[2] Staff should identify if people are in employment or education at the time they are admitted to hospital, help them to maintain contact with families, and resolve any financial issues.[46] The Star Wards initiative has a range of practical ideas for how this can be achieved.[28, 47]

We assessed a number of aspects of acute inpatient services linked to promoting social inclusion. We looked at whether:

- A person's employment or education, and housing status and needs had been assessed and recorded in their care record, and whether advice and help to address social needs were available on wards.

- Assessments identified caring responsibilities and, in particular, whether wards had facilities for service users who were parents.

- Services helped people to keep in touch with their lives outside hospital, and facilitated the involvement of external community organisations.

We found that 59% of all care records included assessment of employment or education status, accommodation status and needs, and caring responsibilities (see table 9). However, between trusts this ranged from 2% to 100% of care records that contained all three assessments. Fifteen per cent of care records included either one or none of these assessments.

Housing support, and financial and benefits advice services were reported to be available on over 90% of acute wards, suggesting that

* For example, less than a quarter of respondents to the most recent Attitudes to Mental Illness Survey agreed with the statement: "Most women who were once patients in a mental hospital can be trusted as babysitters."

Table 9: Recording of social issues within assessments		
Assessments included:	Number out of 3,450 care records	Percentage of care records
Accommodation status/needs	3,036	88%
Employment/education status	2,805	81%
Caring responsibilities	2,334	68%

these may have been established longer. Although available less often, ward managers confirmed that employment and education support services were available on at least 70% of wards (see table 10).

Services do not always consider the parenting and caring responsibilities of adults with mental health problems. We found that establishing whether a service user had caring responsibilities for a child or another adult was less frequently recorded than employment or housing status. According to the PEAT assessments, 80% of units have access to family visiting areas, although the *Parents in Hospital* report found that most settings did not provide child-friendly spaces for family visits.[48] This report also found that having a good policy on family visiting in place did not always translate into good practice and often, just a small number of practical steps would have helped. Our findings showed that toys and

games for child visitors were the least likely to be available (on around two-thirds of wards) compared with other ward facilities.

Keeping in touch with family and friends can be important in preventing isolation. While 84% of wards had access to a telephone that could be used in private, only 38% said that service users had access to the internet. Email can help to maintain contact, so like the MHAC we encourage trusts to consider how they can provide it.

We also found limited evidence of external community organisations coming into wards to facilitate activities (see table 11). The proportion of activities facilitated by external community organisations ranged from 0% to 24% – the average was 5%. This is particularly important for service users for BME groups as a means of providing more appropriate services and instilling confidence.

Table 10: Availability of advice services on 551 wards		
Advice services available	Number of wards	Percentage of wards
Finance/benefits	512	93%
Housing support	508	92%
Employment support	397	72%
Education support	388	70%

Table 11: Proportion of activities facilitated by external community organisations during four weeks in July 2007		
Number of times per bed	**Number out of 68 trusts**	**Percentage out of 68 trusts**
None	2	3%
Less than 1%	3	4%
1-4%	32	47%
5-9%	22	32%
10-14%	5	7%
15% and over	4	6%

One of the barriers to this, cited during the plan improvement visits, was the need to vet individuals that would work with inpatients and the bureaucracy attached to this. However, other trusts have managed to overcome this. It may, therefore, be beneficial for those trusts that have successfully achieved this to share learning with those who have encountered difficulties.

In most trusts, the frequency with which services users were supported to leave the ward to take part in activities in the community was very limited. Over half of trusts only managed to facilitate this once per bed or less during the four-week period (see table 12). Staffing levels were cited as a key factor in determining if planned community-based activities could go ahead, as was making a judgement as to whether an individual could leave based on an assessment of risk.

Table 12: Frequency with which service users were facilitated to leave the ward to take part in community activities during four weeks in July 2007		
Number of times (adjusted by the number of beds)	**Number out of 68 trusts**	**Percentage out of 68 trusts**
Less than once per bed	9	13%
At least once per bed	33	49%
At least twice per bed	11	16%
At least three times per bed	6	9%
More than three times per bed	9	13%

Health promotion

All mental health providers should take steps to ensure that the physical health of people with mental illness is not overlooked, and that provision of healthcare is implemented and managed effectively. Appropriate access to healthcare and health promotion services should be available.[30, 49] Advice and encouragement for healthy eating and giving up smoking should be available on all wards.[28]

Although a number of wards routinely run health promotion groups, MHAC has observed that these are often presented as innovative projects, rather than as a standard element of the ward service.[10] In our review, ward managers reported that diet and healthy eating activities and physical activity sessions were on offer to service users on 95% of wards. Service user group representatives confirmed that 91% of wards had an area to exercise with access to exercise equipment. This is particularly important in view of the weight gain associated with some medication.

All mental health units were required to be smoke-free from 1 July 2008, so it is particularly important that service users are offered support to stop smoking. Ward managers gave a positive picture of access to smoking cessation services, with this support offered in 95% of wards. Fewer wards offered health promotion activities in relation to substance misuse (85% of wards) and pregnancy, contraception and sexual health (58% of wards). However, given the lower results for sexual health promotion, it is perhaps encouraging that just over half of all wards (55%) offered all five health promotion activities we asked about (diet and healthy eating, physical activity, smoking cessation, misuse of substances and sexual health promotion).

Although we are unable to report on the quality of these health promotion activities, it is important that service users are offered the opportunity to engage in activities that promote health and wellbeing.

Ensuring the safety of service users, visitors and staff

The levels of disturbance, violence and aggression on acute inpatient mental health wards have been an ongoing concern.[20, 21] As well as assessing the performance of trusts on safety outcomes, we looked at a number of issues that give an indication of whether care and treatment, and the environment in which these are delivered, is therapeutic and safe.

Levels of violence and aggression

Although there has been progress nationally in implementing good practice that prevents and manages situations, there is a risk that we become desensitised to the issue rather than actively addressing it.

The *2006/2007 National Audit of Violence* pointed to an increase in the frequency and severity of incidents. On acute wards for adults of working age:

- 61% of nurses and 43% of patients had felt upset or distressed.

- 73% of nurses and 31% of patients had been threatened or made to feel unsafe.

- 45% of nurses and 15% of patients had been physically assaulted.*

Similarly, we found in our *Count me in* census for 2007[9] that almost one in eight mental health service users (12%) had been involved in an assault.** And our 2007 survey of mental health staff showed that one in five (20%) had experienced physical violence and one in three (32%) had experienced bullying, harassment or abuse from service users or their relatives during the previous 12 months.

> "Staff handle situations pretty well actually. I haven't felt scared on the ward this time."
> (A patient)
>
> "I've not witnessed any violent behaviour, but the staff appear confident and calm when dealing with distressed patients."
> (A visitor)
>
> "Sometimes I feel that verbal abuse is not taken seriously enough. Sometimes I feel that we are expected to take verbal abuse as just 'part of the job'." (A nurse)
>
> **Quotes from the *2006/2007 National Audit of Violence*[21]**

In the review, we found wide variations between trusts, including:

- 16% of trusts were significantly above the national average for the recorded rate of assaults on inpatients.

- Among all trusts, the rate of service users who had been involved in an assault ranged from 0% to 39%.

- 29% of trusts were significantly above the national average for the proportion of all mental health staff experiencing physical violence, bullying, harassment or abuse, while almost the same proportion were significantly below the average.

- The proportion of all mental health staff experiencing physical violence ranged from 7% to 31%, while the proportion of staff experiencing bullying, harassment or abuse ranged from 17% to 45%.

* These results are based on the responses from 751 patients and 1,097 members of nursing staff from acute wards in England and Wales that took part in the audit. The results for service users and staff from PICU wards were similar for the first two of these questions. However, the reported rate of assaults was much higher, with 61% of the 275 nurses and 26% of the 106 patients from PICUs reporting they had personally been involved in an assault. However, the smaller numbers from PICUs mean that we should be careful in drawing comparisons.

** There was a slight increase on the previous year (2006), when 11% of working age adults on mental health inpatient wards in England had been involved in an assault.

Guidance on good practice has increasingly stressed the importance of using psychological approaches, rather than physical interventions, to manage disturbed or violent behaviour. All service providers should have a policy for training and supervision of employees and staff in relation to the short-term management of disturbed or violent behaviour. The policy should specify who will receive training and the level required, how often they will be trained, and the level of supervision required. It should outline the prevention and management techniques in which they will be trained.

Based on a needs analysis, staff should receive ongoing competency training to recognise anger, potential aggression, antecedents and risk factors of disturbed or violent behaviour. Training should include methods of anticipating, de-escalating and coping with such behaviour.[50]

However, our survey of mental health staff showed that, although nationally around two-thirds of clinical and administrative staff had received training in preventing or handling violence, the proportion of staff reporting having received this training in the last 12 months varied enormously, from 39% to 85%.

The *2006/2007 National Audit of Violence* highlighted the following as main areas for further attention:

- Treating service users with dignity and respect, particularly in relation to administering medication, and involving service users in decision-making about their care and in how the ward is run.

- Offering meaningful occupation to address boredom and ensuring access to activities and therapies.

- Providing service users with good information.

- Developing effective communication systems and ward culture.

- Consistency of staff teams and addressing shortfalls in the levels, competence and training of staff.

- Ensuring sufficient support for frontline staff from senior managers.

- Maintaining environmental safety, including effective safety procedures and avoiding overcrowding.[21]

Therapeutic Management of Violence, due for publication by the Department of Health later in 2008, will offer a definitive guide to support the effective management of violence.

Bed occupancy

High bed occupancy rates can have a negative impact on patients and can contribute to higher incidents of violence and aggression.[20, 21, 51] The Royal College of Psychiatrists has suggested that an ideal average bed occupancy rate should be about 85%, if a safe environment is to be provided.[52]

Trusts gave us information about available and occupied bed days over a six-month period (October 2006 to March 2007). We asked them to include the number of days that service users were actually on the ward, so all types of leave were excluded. The average bed occupancy rate was 87%, similar to the rate of 90% reported to the Department of Health for adult short stay mental health beds during 2006/2007. In our review, two-fifths of trusts had occupancy rates over 90% and one in 10 had rates in excess of 100%, the highest being 106% (see figure 6 overleaf).

Of the eight trusts with occupancy rates above 100%, six served a more urban-based
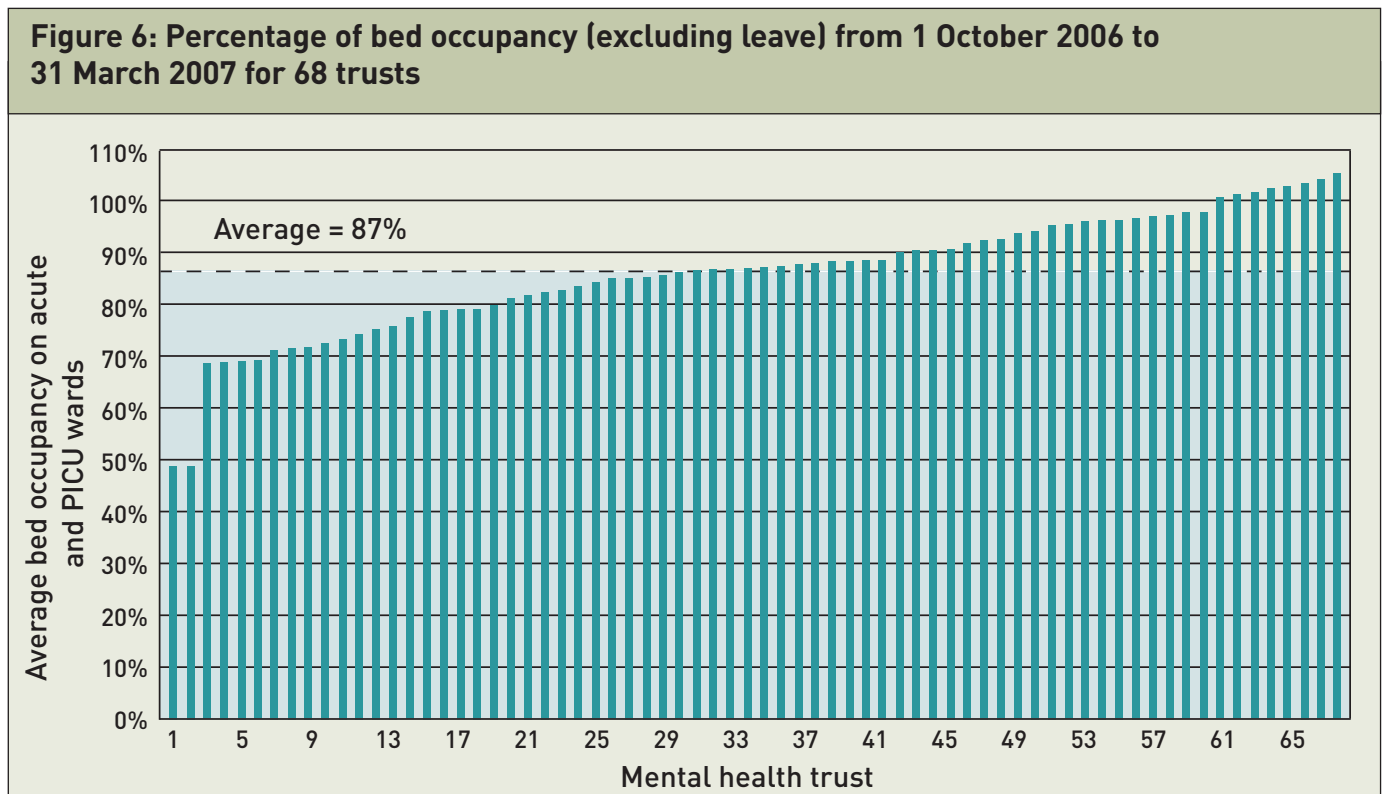
population and six served a higher population of service users from black and minority ethnic (BME) groups (five of these were the same trusts in each case). The average bed occupancy was also greater for trusts serving a higher BME population than the trusts that serve a lower BME population.

London Strategic Health Authority (SHA) had the highest number of trusts operating with bed occupancy rates above the recommended level – three-quarters of London trusts reported their bed occupancy as 90% or more. South Central SHA had the most trusts with bed occupancy below the recommended level of 85% – two-thirds of their trusts reported bed occupancy under 80% (see table 13).

The Mental Health Act Commission (MHAC) has highlighted that some approaches to managing bed occupancy are detrimental to the care of

detained patients. These include service users 'sleeping out', transferring their day time care to other wards and accelerated use of authorised leave under Section 17 of the Mental Health Act.[51]

MHAC has also noted that in some areas there may be insufficient numbers of beds commissioned to adequately address the needs of service users. There is no nationally agreed level of service provision: the appropriate level can only be properly determined by taking into account a range of factors. Service mapping, profiling information, and benchmarking exercises are needed to inform commissioning decisions on the nature, and level, of future provision required and the staffing establishment and other resources required for services to operate effectively.[2]

Figure 6: Percentage of bed occupancy (excluding leave) from 1 October 2006 to 31 March 2007 for 68 trusts

Stategic health authority	Bed occupancy 100% or more	Bed occupancy 90% - 99%	Bed occupancy 80% - 89%	Bed occupancy 70% - 79%	Bed occupancy 70% or less	Number out of 68 trusts
Table 13: The distribution of bed occupancy (excluding leave) rates for 68 trusts by strategic health authority						
East Midlands	0	1	4	0	0	5
East of England	0	4	2	1	0	7
London	3	4	1	1	0	9
North East	0	1	0	1	0	2
North West	1	4	2	0	1	8
South Central	1	1	0	2	2	6
South East Coast	0	1	2	0	0	3
South West	0	2	4	2	0	8
West Midlands	2	3	3	2	0	10
Yorkshire and Humber	1	0	3	5	1	10
Totals	**8**	**21**	**21**	**14**	**4**	**68**

The physical environment

Adult acute inpatient services should provide a high standard of treatment and care in a safe and therapeutic setting. The physical inpatient environment must be organised to deliver a comfortable, relaxed, safe and secure environment.[2]

Since 1992, £1.9 billion has been invested in renewing mental health buildings in England.[19] Despite this, the mental health estate is much older than the remainder of the NHS, with a much smaller amount of allocated funds available to reduce the backlog of maintenance. In 2008, the Care Services Improvement Partnership-National Institute for Mental Health in England (CSIP-NIMHE), in collaboration with Department of Health Gateway Review, Estates and Facilities Division, published *Laying the Foundations*, a workbook on service redesign and capital investment to help commissioners and providers develop new schemes that better suit the model of care.[19] This workbook contains a downloadable

template to assist services in defining their service aims and desired outcome measures.

During some of the plan improvement visits, the teams identified health and safety issues that raised concerns about the monitoring of the physical environment – particularly about whether those responsible for commissioning and providing services were giving less priority to the environment within mental health inpatient wards compared with acute services.* This also raised questions about potential gaps in focus of regulatory assessments and about the frequency and volume of independent visits to ensure the safety of service users on the ward. These risks were not always adequately recognised by ward staff at the time, reinforcing the need to develop risk management practice.

Provision of activities and facilities

One of the key changes proposed by the Star Wards initiative to improve the quality of service users' experience of inpatient wards is providing a programme of daily activities, not only to eliminate boredom but to actively contribute to accelerating recovery.[28, 47] The *2003-2005 National Audit of Violence* found that many inpatient wards did not offer a structured and therapeutic system of care.[20] There is an obvious link between boredom and a lack of things to do, and incidents of violence, which highlights the importance of positive engagement of service users.

Recommendations have been made about the facilities that should be available and the range of activities that should be provided.[28, 36, 53] The emphasis is on consulting service users to develop the programme and ensuring that what is provided responds to individual needs.[2, 20, 36] Staff should be given planned and protected time to make sure activities and interventions are provided regularly and routinely.[36] Service users

from BME groups should be given access to culturally appropriate opportunities and materials for therapy leisure and education.[54]

The frequency, regularity and diversity of activities should be monitored.[55] Ninety-one per cent of trusts reported that they had reviewed the provision of activities at ward level within the last year. It is important to do this on an ongoing basis to ensure that activities are appropriate, effective and culturally sensitive.

Feedback from the service user group representatives indicated a good range of facilities available on each ward:

- 100% of wards had current books and magazines to read and 99% had a stereo and/or CD player.

- Over 90% of wards had a television, a DVD and/or video player, and an area to exercise with access to exercise equipment.

- Least likely to be provided were toys and games for visiting children (64% of wards) and 24-hour access to refreshments and snacks (68%).

However, while we checked the availability of these facilities, we are unable to draw any conclusions about service user access to them. For instance, during our scoping visits, various wards had gym equipment available but access was limited according to the availability of trained staff who could supervise use of the equipment.

We also asked trusts to audit the range of activities provided over a four-week period in July 2007. This was positive: 80% of wards provided eight of the activities we asked about (out of a possible 13 activities for mixed sex wards and 12 for single sex wards). However, the findings did suggest that the availability of activities during evenings and at weekends could

* These included concerns relating to the fire integrity of the building, infection control, privacy and dignity issues and general upkeep and maintenance.

be improved. On average, 28% of activities were provided then, but this ranged from 4% to 49% of those activities provided. Of particular concern, none of the activity sessions we asked about were delivered at the weekend or during the evenings on 8% of wards.

Promoting sexual safety and sexual health

The sexual safety of inpatients, particularly women, is a key safety issue.[56] The CSIP-NIMHE *Informed Gender Practice – mental health care that works for women* provides specific guidance on appropriate care for women who are acutely mentally ill. [18]

The National Patient Safety Agency report section on sexual safety identified 122 incidents, of which a small number were of alleged rape. Some of these incidents involved a staff member. A survey conducted by Community Care identified over 300 sexual assaults in the past three years. Both these studies reflected earlier findings by Mind that there was a significant degree of underreporting of sexual harassment and abuse. An environment where sexually inappropriate or derogatory remarks are not checked contributes to creating a culture where more serious incidents may be tolerated.

Experiences of sexual abuse as a child or adult and/or domestic violence have a long-term impact on a person's emotional wellbeing, and are factors that predispose someone to mental health problems.[57]

The need for greater awareness of the risks of sexual vulnerability of mental health inpatients and greater protection for patients has been identified. All service users are potentially vulnerable to sexual aggression and violence and the emphasis should be on identifying and curtailing the behaviour of the predator or

abuser, who may be an intruder, ward visitor, service user or member of staff. Although women tend to be the victim in the vast majority of cases, men who are survivors of child sexual abuse, gay, bisexual and transgendered service users can also feel vulnerable. People with a learning disability and others whose mental capacity is limited may be particularly at risk.

The Department of Health recommends that the initial assessment of each patient's needs should include a consideration of the risk of the patient being abused and that assessments should aim to identify at an early stage any patients who may be predatory or likely to abuse or offend.[58]

Our audit of care records looked at practice in both of these areas. We found that:

- Assessment of the risk of sexual vulnerability was the least likely of the risk assessments we asked about to be completed, although it was more likely to be conducted for women than for men. The range in the proportion of care records recording this information was immense, ranging from 4% to 100%.

- Recording of the assessment of identification of predatory behaviour, or the potential to abuse or offend was completed for nearly three-quarters of all care records audited, although this was more likely to be conducted for men than for women. There was also wide variation between trusts in the rates of recording the outcome of this assessment (from 4% to 100%).

These inconsistencies in practice raise some fundamental questions about staff awareness and the training they receive. We found enormous variation. 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 (2005 to 2007), even as part of other risk assessment training. On the other hand, four trusts reported that 100% of staff had received this training. Around three-fifths (61%) of trusts reported less than 50% of staff having received this type of training (the national average was 37%), which points to this as a key area for development. Good training and practice in assessing these risks is a precursor to effective interventions.

National guidance also stresses the importance of inpatient units providing access to appropriate advice and services on contraception, pregnancy and sexual health.[18] Ward managers said that service users were least likely to be offered sexual health advice out of the five options we gave them, although with 58% of wards reporting access to this advice and help, the picture was better than expected.

Single-sex accommodation promotes privacy and dignity and can help to ensure sexual safety. All mental health units in England that provide mixed-sex accommodation were expected to review inpatient facilities by 2002[59] to ensure compliance with Department of Health guidance.[56]

The Department has given a clear public commitment to eliminating mixed-sex accommodation for inpatients. This can include providing single-sex wards, or combinations of single rooms and single-sex sleeping accommodation.[60] For new buildings, this includes separate sleeping areas for men and women and segregated bathrooms and toilets. Effective segregation on wards can be achieved which avoids a person having to pass through (or close to) an area dedicated to the opposite sex.[2, 60] Ward layouts should minimise the risk of

overlooking or overhearing from members of the opposite sex. Men-only and women-only lounges are recommended[36], and will be a requirement of the revised Mental Health Act Code of Practice from November 2008.[27]

Over the last three years, the *Count me in* census has been monitoring this situation. Changes to the definition have made it difficult to compare findings between the years. The census for 2008 has been further refined to include separate questions on sleeping accommodation, bathrooms and day rooms. The *2006/2007 National Audit of Violence* found that in wards for adults of working age, 92% had single-sex toilets, 93% had single-sex bathrooms and 51% had single-sex day areas.[21] Additionally, when asked, 19% of inpatients said that they had to share space with members of the opposite sex when they did not want to.

Our review also found that, as at the end of March 2007, 65% of beds were in single bedrooms. Based on information from the patient environment action team (PEAT) assessments, 64% of mental health inpatient sites had women-only day areas, although as the PEAT assessments are carried out in relation to hospital sites, this may mean that more than one ward shares a women-only day area.

For 2007/2008 and 2008/2009, the Department of Health made extra funding available to support improvements to estates – this has included £30 million for improvements to acute wards for gender separation, which can promote sexual safety.[61]

Detained patients going absent without authorised leave

Another key safety concern is when admitted inpatients leave or go missing from the ward, especially those who have been detained under the Mental Health Act.

Although negative outcomes are rare, research suggests that 4% of all service users harmed themselves or others in some way following their absence from the ward[62] and 227 (27%) of the 856 suicides among inpatients between April 2000 and December 2004 occurred after the person had gone missing from the ward.[63] Figures from MHAC show that 49 (15%) of the 326 "unnatural" deaths of detained patients reported to them between April 2004 and March 2008 were while the person was absent without authorised leave.

Service users are more likely to go missing early in their admission, and returning them to the ward can be time consuming for a number of agencies.

We asked trusts to report the number of occasions during a six-month period that detained patients were absent without authorised leave. Trusts also gave us information on the total aggregate number of days that service users were absent (counting every midnight that a service user was away from the hospital). Both these sets of figures include those service users who did not return from authorised leave as scheduled.

During the six month period 1 October 2006 to 31 March 2007, nationally:

- Detained patients were away from the ward on unauthorised leave on 2,745 occasions for a total of 8,870 nights.

- The period of absence per trust ranged from one to 15 nights, with an average of two to three days per person.

- The median number of detained patients that went absent without authorised leave per trust during the six months was 24, for an aggregate of 45 days.

These findings suggest that, although the frequency with which detained patients were absent without leave was relatively high, this was generally for brief periods and that the rate varied considerably between trusts. Four trusts (6%) had a significantly higher rate of service users going absent without authorised leave compared with the rest. These trusts were scored either "weak" or "fair" for the review overall. These trusts in particular should consider what action they can take to minimise the likelihood of detained patients going missing.

A good practice guide, *Strategies to Reduce Missing Patients*, to be published in summer 2008, offers relevant advice to staff in mental health inpatient settings. This will emphasise the importance of evaluating the risk of service users going missing and developing therapeutic relationships and interventions as well as employing practical strategies to minimise identified risks. The guidance contains a self-assessment tool that can be used to assess local situations and to develop planning to address problem areas. In addition, City University has produced an anti-absconding workbook to inform practice.[64] This includes information about interventions that have been proven to reduce the frequency of patients going missing.

Use of bank and agency staff

It is recognised that high use of bank and agency staff leads to problems in providing a consistent approach to care.[2] The use of such staff should be monitored. Although we have heard of good practice in developing a pool of

bank staff who are trained and prepared to work on the wards, it remains a concern where regular ward staff are required to work long hours through the staff bank. Research has demonstrated a link between the presence of regular staff on the ward and lower rates of incidents of physical aggression and self-harm.[65]

Over a six-month period, we found that nationally the use of bank and agency nursing staff was 16% on acute wards and 21% on psychiatric intensive care units (PICUs), but that their use varied extensively. At best, none of the staffing of the acute wards and 2% of PICU staffing was from bank and agency. At worst, the rates in one trust were 54% on acute wards and 53% on PICUs. In consultation, we set a threshold for 30% of nursing staff to be from bank and agency staff – a trust that had a higher proportion was scored "weak" for the relevant indicator. Nationally, on average 14%

of trusts were above this threshold during the period.

There were regional differences in the results. Trusts in the South East Coast SHA reporting the highest use of bank and agency staff in both acute wards and PICUs. Use was also high on both types of ward in London trusts and on PICUs within the East of England SHA (see table 14).

Table 14: Average percentage of bank and agency staffing by strategic health authority		
	Average % of bank and agency staff on acute wards in 68 trusts	Average % of bank and agency staff on PICUs in 50 trusts
East Midlands	13%	17%
East of England	17%	33%
London	26%	28%
North East	9%	10%
North West	16%	18%
South Central	18%	23%
South East Coast	37%	33%
South West	12%	14%
West Midlands	12%	20%
Yorkshire and Humber	12%	12%

Implementation of risk management systems

The clinical negligence scheme for trusts (CNST) standards, in place at the time of the review, provided an overall assessment of a trust's clinical risk management systems. For 2007, the majority of mental health trusts (81%) had achieved CNST Level 1.

This is consistent with the *2006/2007 National Audit of Violence* findings, where 90% of wards for adults of working age in England and 100% in Wales reported that they had policies in place for risk assessment and risk management.

However, only 19% of mental health trusts had achieved CNST Level 2. This suggests that there is more to be done to implement good risk management practices.

The CNST standards were replaced in April 2008 by the NHS Litigation Authority risk management standards for mental health and learning disability trusts, which cover corporate and non-clinical (health and safety) risks as well as clinical ones.

Providing appropriate and safe interventions

Service users should be able to expect that the treatment they receive once in hospital is safe, therapeutic and appropriate to their needs. This section reviews our findings in relation to:

- Administration of medication during the first week of admission

- Recording diagnosis

- Assessing capacity to consent

- Physical health checks

- Accreditation of electro-convulsive therapy clinics

- Availability of therapies and access to activities

- Support for people with a dual diagnosis.

Administration of medication within nationally recommended daily doses

Current evidence does not justify the routine use of high dose antipsychotic medication (that is, more than 100% of the maximum recommended daily dose according to nationally recognised limits) in general adult mental health services, either with a single medicine or in combination.[66,67,68] During a crisis, dosages may need to be increased, but these should be reduced once the crisis has subsided and the administration of this medication carefully monitored throughout.[22]

The Prescribing Observatory for Mental Health (POMH-UK) has conducted two audits on the prescribing of high dose antipsychotics for patients on adult acute and psychiatric intensive care wards. It found that 36% of service users were prescribed a higher than recommended dose when the first audit was conducted in 2006, and 34% when this exercise was repeated a year later.

We asked trusts to check the number of days during the first seven days after admission on which service users had actually received medication that exceeded the maximum dosages recommended in the British National Formulary (BNF).[67] This used a similar method as that used by POMH-UK to calculate the total dose, but looked instead at the doses administered rather than prescribed.

The results were positive: 94% of care records indicated that service users did not receive medication above BNF levels on any day during the first week of admission. However, at least two fifths of trusts (41%) had more than two service users (out of the 50 whose records had been audited) that had received a high dose on at least one day during the first week. The proportion of service users receiving medication above BNF levels on all seven days was 2% (53 service users) and these service users came from 22 trusts.

Concern has also been expressed about service users from black and minority ethnic (BME) groups being routinely given high dose antipsychotic medication, particularly black men.[34] However, there were no significant differences between the results for service users who were from the White British group and those from BME groups, in relation to a pattern of days on which service users received medication above BNF limits during their first week in hospital (see table 15).

This is in keeping with the findings of a recent study in south London, which found that ethnicity was not significantly associated with the dose of antispychotic medication, the prescribing of high dose antipsychotics or the use of atypical antipsychotics.[69]

| Table 15: Number of days on which service users received medication above BNF limits by ethnicity					
Number of days	White British group		Black and minority ethnic groups		Total number of valid care records
	Number of care records	% of care records	Number of care records	% of care records	
0	2,520	95%	643	93%	3,163
1	47	2%	23	3%	70
2	19	1%	3	0%	22
3	17	1%	1	0%	18
4	7	0%	5	1%	12
5	9	0%	1	0%	10
6	9	0%	4	1%	13
7	38	1%	15	2%	53
Total	**2,666**	**100%**	**695**	**100%**	**3,361**

However, we recognise that medication may be increased or added to after the first week of admission, resulting in further or higher doses that produce a cumulative high dose. The Royal College of Psychiatrists has recommended that each service should establish the audit of antipsychotic doses as a matter of routine practice.[66] We therefore encourage trusts to monitor this situation on an ongoing basis, to ensure that the administration of medication is within nationally recommended doses. This should take account of ethnic differences within ethnic groups. The Delivering Race Equality programme has commissioned work to review prescribing practices for people from BME communities in 10 mental health trusts in England and will make the results of this review available nationally in 2009.

Recording of diagnosis

As identified in the previous section, the quality of coding of ethnicity data has improved over time. However, the findings were not so positive for the quality of coding of diagnosis. It is important that information about diagnosis is recorded and shared to help choose appropriate interventions for people, and for more general workforce planning. This is also the case for any secondary diagnosis: for example if only one diagnosis is made, a secondary dual diagnosis may not be assessed or treated.

The Hospital Episode Statistics showed that nationally an average of 76% of records had a valid diagnostic code, compared with 93% for the recording of ethnicity. However, this masked a wide variation – at best 100% of records contained a valid diagnostic code; at worst this was as low as 8% in one trust (see figure 7 overleaf).

Figure 7: Data quality on ethnic group and diagnosis (Hospital Episode Statistics, 2006/2007 (quarters 1 to 3) and Mental Health Minimum Data Set, 2006/2007 (quarter 1))
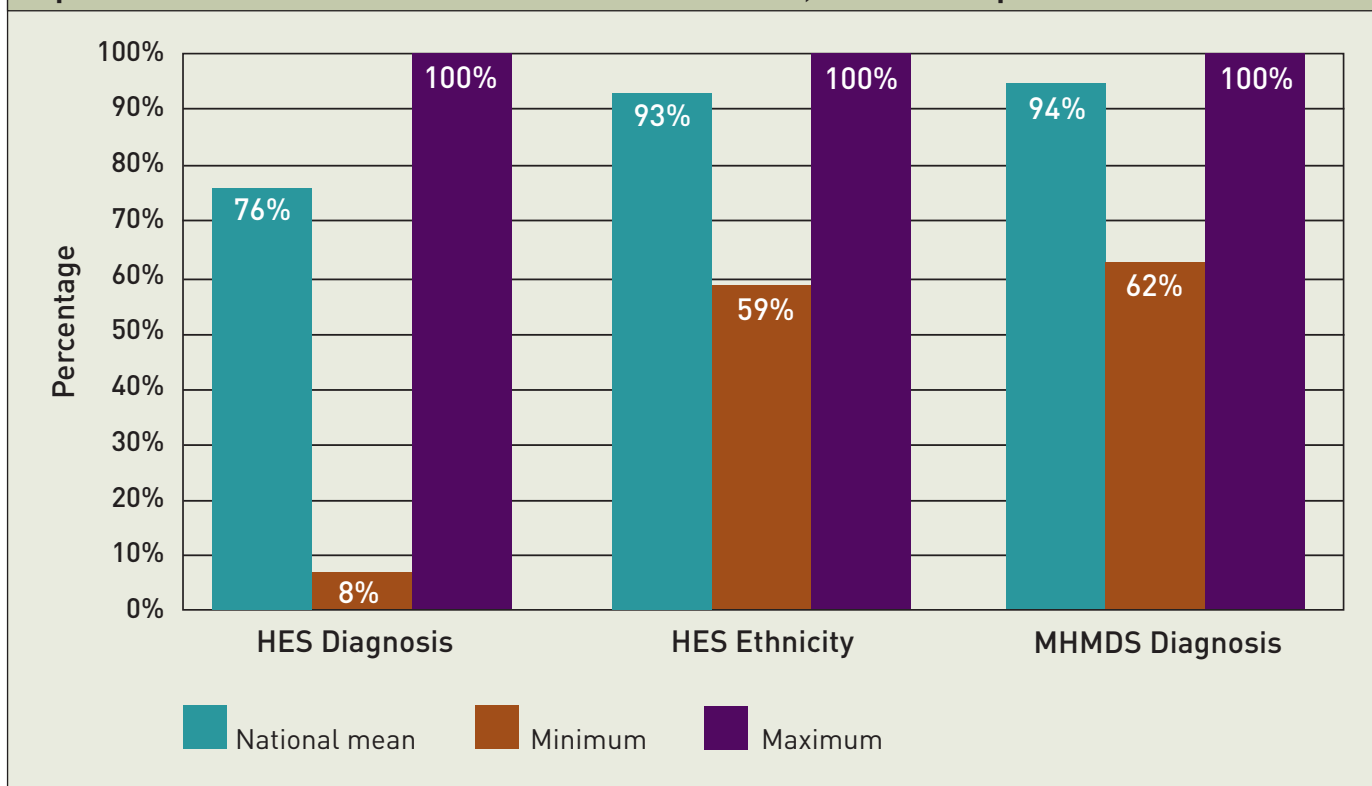
Capacity to consent

Valid consent is required from all patients before medical treatment can be given, except where common law or statute provides authority to give treatment without consent. The Code of Practice for the Mental Health Act 1983 states that, even where the Act allows treatment to be given in the absence of consent, service users' consent should always be sought and their mental capacity and consent or refusal should be fully recorded in the patient's healthcare notes.[27] Further assessment of capacity should be carried out whenever a specific treatment decision is proposed, as capacity can be variable over time.

The Mental Capacity Act 2005 requires that service users are assumed to have capacity, and are therefore able to make choices about care and treatment.[70] Only where it can be demonstrated that such capacity is lacking, can decisions about care and treatment be taken for the service user in their best interests. Clinicians should have assessed and recorded their capacity and consent status in relation to the arrangements made for their care and treatment.[27,70]

We found that there is room for improvement in relation to the routine assessment and recording of mental capacity to consent. This was recorded for just over half of service users sampled – with wide variation between trusts from 0% to 100% of the care records.

Physical health checks

The standardised mortality ratio for people with severe ongoing mental illnesses is two and a half times greater than the national population average.[71] People with conditions such as schizophrenia and bi-polar disorder are at increased risk of physical conditions such as heart disease, diabetes, obesity, respiratory conditions, and infections.[35,49]

Guidance from the National Institute for Health and Clinical Excellence (NICE) on depression and schizophrenia recommends that services make regular full assessments of service users' physical health.[72, 73] These checks should be carried out before medication is prescribed, when it is being changed and to monitor any side effects. Once in hospital, the admission may be a good opportunity to reassess a person's physical health (especially in light of a treatment plan) and to reconcile the prescription of medication at the point of admission and discharge.

On the day of their admission or as soon as they are well enough, the patient should receive a structured standard medical assessment that matches the assessment undertaken in the Quality and Outcomes Framework in the General Medical Services contract.[36] In 2008, the Royal College of Psychiatrists' scoping group on physical health in mental health will be publishing service standards that will detail the range of physical health checks that should be conducted.

We assessed whether a range of physical health checks had been carried out on admission. We found that:

- 86% contained a baseline physical health examination that recorded details about the service user's cardiovascular system, respiratory system, gastrointestinal system, central nervous system and musculoskeletal system.

- 80% recorded past and current use of physical, psychotropic and non-prescribed medication that the service user was taking at the point of admission.

- 77% included a baseline haematological and biochemical screening (baseline urea, full blood count, electrolytes, liver function tests, blood glucose tests, lipids and cholesterol levels).

- 69% of care records included a baseline lifestyle assessment recording the service user's body mass index, smoking history and diet and nutrition.

- 17% indicated that an electrocardiogram (ECG) had been completed. ECGs are particularly important for detecting the impact of medication on the heart.

On the whole, the completion rate for each of these assessments was positive apart from the last one. However, the picture was not so good when we looked at the range of checks completed for individuals. For example, only 56% of care records included the physical health examination, lifestyle assessment and haematological and biochemical screening checks, suggesting that the range of checks could be more comprehensive.

Electro-convulsive therapy clinics

NICE has recommended that electro-convulsive therapy (ECT) should only be used for the treatment of certain conditions such as severe depressive illness, a prolonged or severe episode of mania, or catatonia.[74] ECT should be used to gain fast and short-term improvement of severe symptoms after all other treatment options have failed, or when the situation is thought to be life-threatening.

In recent years, practice guidelines have been introduced to improve standards for administering ECT, and implementation of these guidelines has been monitored through ongoing audit.[75,76] However, variation in the use and practice of ECT has been noted.[74] We assessed service users' access to an ECT clinic that had been enrolled with, or accredited, by the Electro Convulsive Therapy Accreditation Service (ECTAS). We found that two out of every five trusts (41%) had ECT clinics that had been accredited by ECTAS and around a quarter had no registered or accredited clinics. The remaining third either had some clinics enrolled or accredited, or at least had all of their clinics enrolled with ECTAS pending accreditation. We encourage trusts to follow the standards set by ECTAS[75] to ensure that ECT administration complies with good practice.

Availability of a range of therapies and interventions

All inpatients should have access to a broad range of appropriate psychological therapies and interventions.[77] They should be offered specific psychosocial interventions appropriate to their presenting needs and in accordance with national standards (for example, NICE guidance).[36] Inpatient services should offer a range of three or more psychological interventions that are known to work.[36]

We assessed trusts in relation to a basic range of therapies and interventions that should be available on each ward. Although wards were most likely to provide 'talking therapies', the range of therapies that we included in this definition was very broad. (We defined talking therapies as counselling, cognitive behavioural therapy, solution-focused brief therapy, faith and spirituality-based counselling, dialectical behaviour therapy and anxiety management.)

Future assessments would benefit from including a more defined range of talking therapies, particularly access to cognitive behavioural therapy. Despite this, the findings show that 6% of wards had no basic talking therapies available (see figure 8). Of the other therapy types:
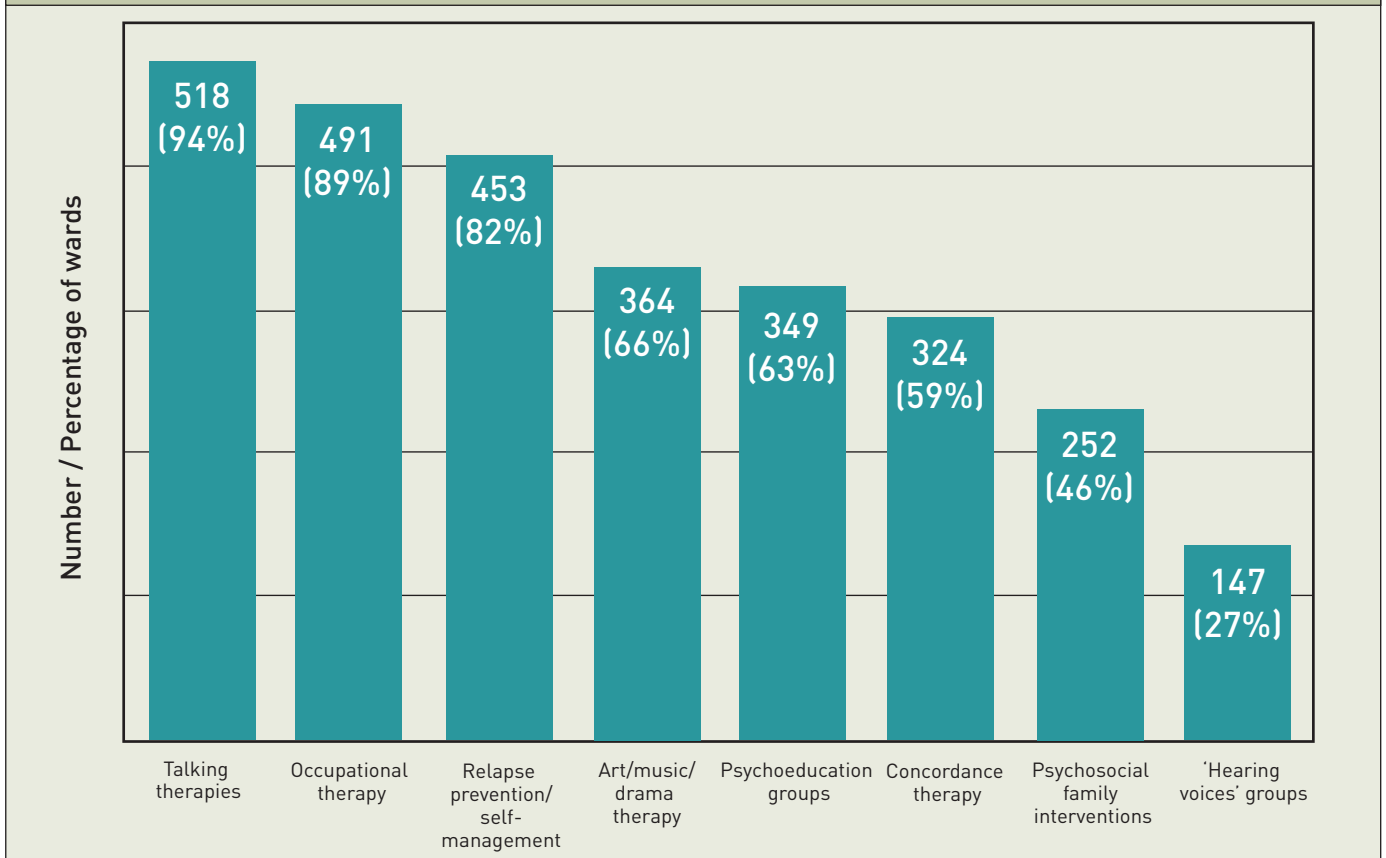
- Wards were least likely to provide 'hearing voices' groups and psychosocial family interventions.

- Around one in ten wards had no access to occupational therapy.

- No wards provided all of the therapy types we asked about.

- Just under a third of wards (31%) provided three types of therapy or less, and around a fifth (18%) provided less than three.

The national picture suggests that the range of available therapies and interventions could be improved. Furthermore, even where therapies are available, our findings do not tell us whether service users can readily access them. For example, there may be waiting lists for some types of therapy.

However, our findings provide a baseline against which future access to psychological therapies for inpatients could be assessed, particularly as the national Improving Access to Psychological Therapies programme is rolled out nationally. This is especially important for people from black and minority ethnic groups, who are less likely to have access to talking therapies.[34] Actively monitoring access to, and take up of, psychological therapies by ethnic group would further complement work to implement Delivering Race Equality effectively.

There is also scope for the development of specific psychological therapies. NICE guidelines indicate that family therapy is one of the most consistently identified interventions

Figure 8: The availability of different types of therapy on 551 wards

	Number / Percentage of wards
Talking therapies	518 (94%)
Occupational therapy	491 (89%)
Relapse prevention/ self-management	453 (82%)
Art/music/ drama therapy	364 (66%)
Psychoeducation groups	349 (63%)
Concordance therapy	324 (59%)
Psychosocial family interventions	252 (46%)
'Hearing voices' groups	147 (27%)

that is effective in reducing relapse and preventing admission. There is a growing body of research that indicates that starting family therapy during an acute phase of illness can improve outcomes. However, as our joint review of community mental health services showed, access to family interventions for people with schizophrenia was limited[5] – of those for whom family intervention was appropriate, only 53% had received at least one family intervention session during a 12-month period.

Working with people with a dual diagnosis

The *2006/2007 National Audit of Violence* found that 85% of nursing staff and 18% of patients on acute wards reported trouble because of service users getting drunk.[21] The results were similar for problems associated with service users taking illegal drugs: 88% and 20% respectively.

Provision for people with a dual diagnosis has been identified as a key area for development in acute inpatient wards.[41, 49, 79] Research suggests that up to half of all people in acute wards have problems associated with substance misuse[79], yet fewer than a fifth receive treatment for it.[41] Inpatient wards are responsible for taking an integrated approach to treatment, whereby both mental health and substance misuse needs are addressed at the same time, in one setting, by one team.[78]

In 2006/2007, the themed review for the autumn assessment of mental health services focused

"Problems can arise when service users deal or take drugs on the ward. This leads to increases in violence and aggression towards staff and between service users."

"There's been a 90% reduction in drug and alcohol-related incidents in the past year following implementation of a new local ward specific policy."

Nurses quoted in the *2006/2007 National Audit of Violence*[21]

on dual diagnosis, including strategic planning, service delivery, health promotion, training and practice development. To ensure effective provision for people with a dual diagnosis, the report from this review, published in July 2008, included recommendations on:

- Clear designated local responsibility for the strategic development of dual diagnosis services.

- Embedding dual diagnosis within the joint strategic needs assessment and within assessment and care planning processes.

- Strengthening workforce capabilities.

- Monitoring service user views and satisfaction and effective recording of outcomes defined by them as the basis of a local outcomes strategy.[80]

Providing high standards of care for people with a dual diagnosis requires careful consideration of all aspects of the acute care pathway and identification of what is required at each stage. In this review, we focused on a few specific dual diagnosis standards including assessment of patterns of substance misuse, provision of health promotion activities, and provision of training and specialist support. Service users

who had a primary diagnosis relating to psychoactive substance use formed 9% of our audit of care records, the third highest group in terms of diagnosis after schizophrenia and mood affective disorders.
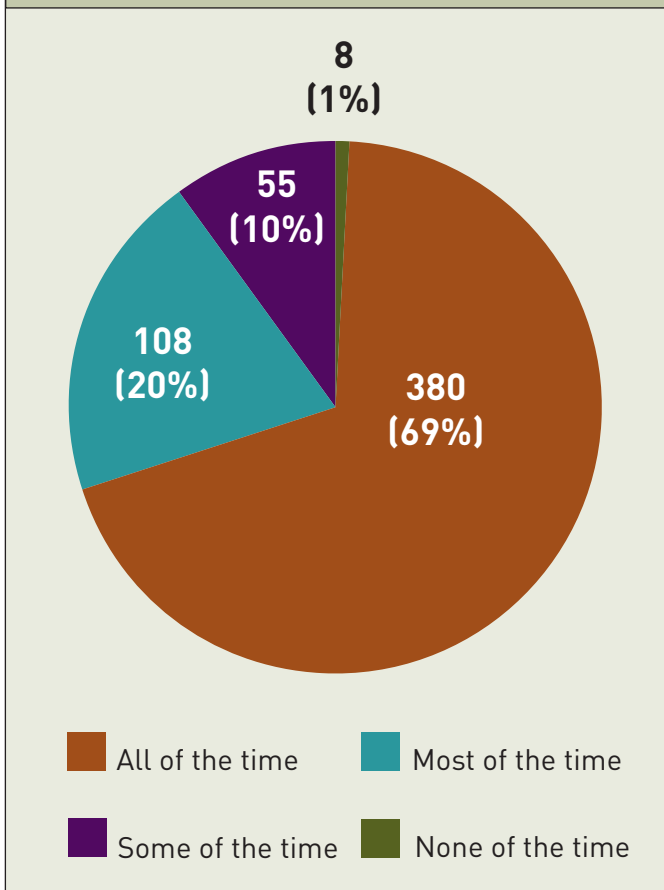
When someone is admitted to hospital, it is important to consider the physical health risks associated with drugs and alcohol as part of a comprehensive physical health check. Screening, clinical history and physical health checks are important for identifying problem drinking and substance misuse but, as this review found, the relevant range of checks is not carried out consistently. In terms of assessing risk, five trusts managed to assess patterns of substance misuse consistently for all service users included in the audit of care records, while staff from another trust had only conducted this assessment for just over half of the care records selected.

Substance misuse can be a significant problem in the ward environment, but a balance needs to be achieved between implementing robust safety and security measures which minimise the extent to which substances are used, and retaining a therapeutic environment which respects the dignity of individuals and enables substance use to be addressed in a therapeutic manner. Staff in mental health services should be able to offer basic, accurate and up-to-date information about the effects of substances on mental and physical health and vice versa.[81] We asked ward managers to indicate whether health promotion activities about substance misuse were offered to service users. Most (85%) indicated that this was available, although not as readily available as some of the other health promotion activities.

Working with people with a dual diagnosis requires an integration of mental health and

Figure 9: Access to dual diagnosis services on 551 wards if required for the service user

- **All of the time** — 380 (69%)
- **Most of the time** — 108 (20%)
- **Some of the time** — 55 (10%)
- **None of the time** — 8 (1%)

substance misuse treatment.[82] Our review asked whether acute inpatient wards had access to services specialising in dual diagnosis, including referral for screening and brief interventions for reducing alcohol and drug related harm.* Just under 90% of wards had access "all of the time" or "most of the time" (see figure 9).

Despite the high levels of co-morbid mental health and substance misuse problems, inpatient staff have generally received little training in the area of dual diagnosis.[78] The Chief Nursing Officer's review of mental health nursing has recommended the need for improved training for mental health nurses in substance misuse management, both before and after registration.[30]

This picture was supported by our findings. Based on our 2006/2007 survey of staff working in mental health services, we found that among clinical mental health staff nationally, only an average of:

- 26% reported having received training paid for or provided by their trust at any time in how to ask service users about their use of alcohol or drugs (including illegal drugs); this ranged between trusts from 14% to 46%.

- 22% reported having received training in how to handle patients who are drunk or under the influence of drugs; this ranged between trusts from 12% to 39%.

These were the poorest results of all of our indicators about staff training, with all trusts being scored "weak". Evidence from our plan improvement visits highlighted the need to raise staff awareness and develop skills further in managing drug and alcohol issues, particularly as the problem of service users bringing drink and drugs onto the ward was flagged up as an ongoing problem. Moreover, although the findings were more positive for assessment of substance use and health promotion activities to address these issues, the low levels of training reported raise significant questions about the quality of these interventions.

This is in keeping with the findings of the theme review of dual diagnosis, which identified wide variation in the level of competence achieved by staff in acute inpatient wards. [80]

* The role of dual diagnosis services is to support mental health teams to conduct assessments and deliver interventions on the wards as part of an integrated treatment model

Increasing the effectiveness of the acute care pathway

> "If the problem lies within your house, things in the home or something happened in your home, you want to get away from it – just go away from it a few days to give you breathing space."
>
> "Well, my team helped me get out of hospital... I was home for Christmas, which I spent with the kids."
>
> **Service users who gave their views on alternatives to admission and on crisis resolution and home treatment services, National Audit Office report 2007[11]**

The Department of Health's *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*, published in 2002, envisaged inpatient services as part of a well functioning care pathway for services users during a crisis. When the care pathway was working effectively, this would ensure that service users:

- Have access to alternatives that may prevent an admission to hospital.

- Are only admitted to hospital when it is the most appropriate course of action.

- Receive the appropriate care and treatment as an inpatient.

- Are in hospital no longer than is necessary.

- Are supported to make the transition back home.

In the review, we assessed a number of issues that give an indication about the effectiveness of the care pathway including:

- Alternatives to admission and access to help in a crisis.

- The role of crisis resolution teams.

- Assessment and care planning processes to support the care pathway.

As indicated, none of the participating trusts achieved a score of "excellent" on the effective care pathway criterion.

The role of crisis resolution home treatment teams

Crisis resolution home treatment (CRHT) teams provide intensive support to people during a mental health crisis in community settings, as an alternative to hospital admission. A key role of these teams is to act as gatekeeper to all people requiring access to inpatient mental health services or other emergency care, to identify whether an alternative to admission is appropriate.

This function is also seen as vital to effective bed management, through ensuring that criteria for admission are consistently applied. CRHT teams also help people to leave hospital while still in an acute phase of their illness, and return home sooner. They are therefore critical to the effective functioning of the care pathway.

A recent study by the National Audit Office (NAO) highlighted the progress that has been made in establishing CRHT teams and the positive impact they have had in reducing pressure on beds and preventing admissions to hospital.[11] However, they also concluded that:

- There was wide regional variation in CRHT team provision relative to local need.

- A lack of dedicated input from key health and social care professions restricted the ability of teams to provide comprehensive, multi-disciplinary care.

- Only half of their sample of 500 admissions had been assessed by CRHT, rather than all as intended.

- Where a CRHT worker was involved in an assessment, it was far more likely that home

treatment would be considered as an option and increased the chances of the team being involved in an early discharge.

In our review, we looked at the CRHT teams' gatekeeping of admissions, support of early discharges and the commissioning of home treatment episodes. In relation to CRHT gatekeeping admissions, we found that:

- Over a six-month period, CRHT teams nationally had acted as gatekeepers in 61% of the 39,223 admissions to acute wards.*

- There was a wide range in the proportion of admissions gate-kept by CRHT teams, varying from 9% to 100% of admissions.

- In around a third of trusts, 50% or less of admissions were gate-kept by the CRHT, while a similar proportion of trusts were

gatekeeping 90% or more of admissions, with 11 trusts achieving 100%.

The feedback from our development sites and the plan improvement visits indicated that there were a number of factors that hindered effective gatekeeping of admissions. These included inappropriate referrals (particularly from primary care due to a lack of understanding about the team's role), other teams bypassing the system, or reluctance to transfer the authority to gatekeep, particularly from medical staff. As the care pathway into hospital for people from some black and minority ethnic groups differs[83] – African Caribbean and Black African service users are more likely than White British service users to come into contact with inpatient services through the criminal justice system – ensuring sufficient access to CRHTs for these service

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Figure 10: The relationship between crisis resolution home treatment team gatekeeping of administrations and facilitation of early discharge in 68 trusts
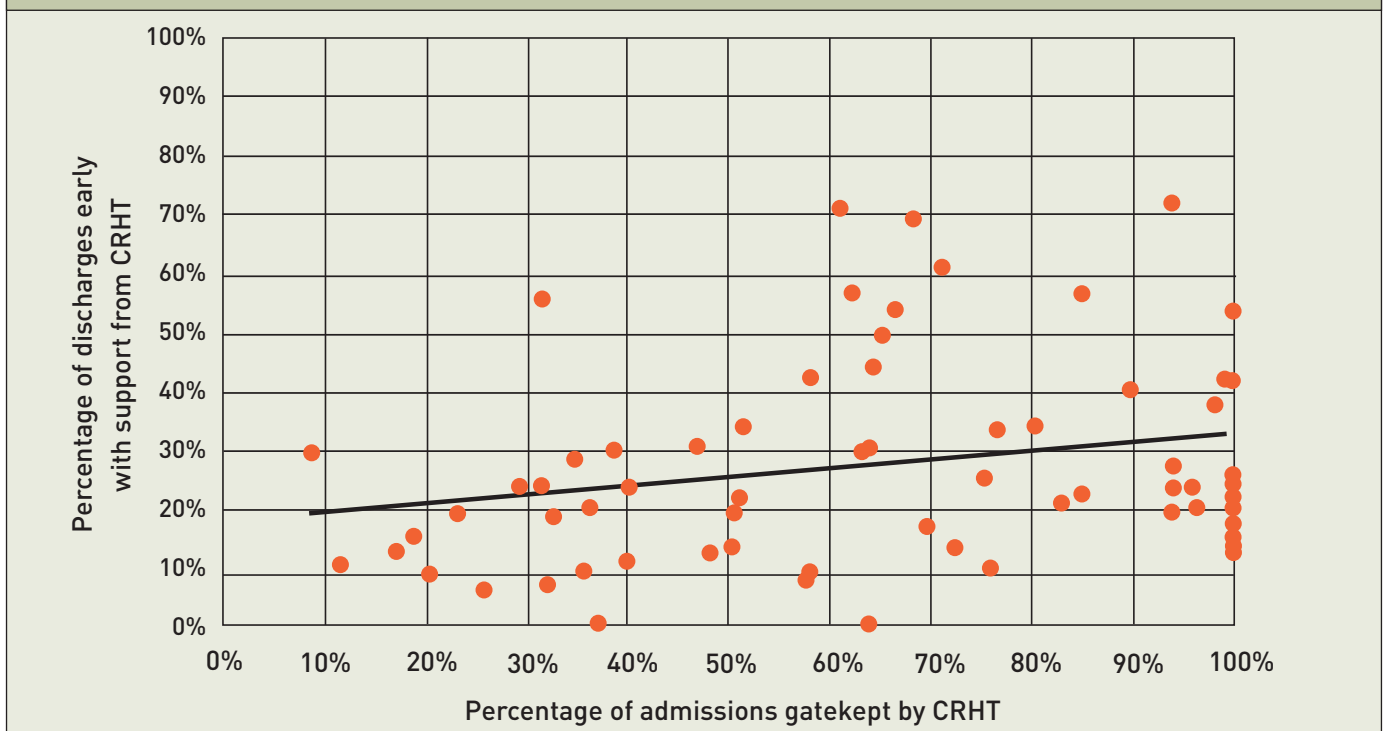
* The NAO report found that CRHT staff had been involved in 53% of admissions and had influenced the decision to admit in 46% of cases – these findings based on an audit of 500 admissions (20 hospital admissions to 25 trusts) conducted in February to April 2007.

users is also important, and warrants further investigation and monitoring.

The involvement of CRHT teams in facilitating early discharge nationally was at a much lower level, although the variation between services was equally pronounced. Over the same six-month period, a quarter of the 39,801 discharges from acute wards occurred early with support from CRHT teams.* This ranged from two trusts where there was no involvement from CRHT teams in facilitating early discharge, to two trusts where CRHT teams were involved in over 70% of discharges. Our review also showed that the more often teams tended to gatekeep admissions, the more likely they were to be facilitating early discharge (see figure 10). This agrees with the findings of the National Audit Office report.

There is a national target for CRHT teams to treat 100,000 people a year. We assess the performance of PCTs as commissioners of mental health services in relation to meeting this target as part of our annual rating of services. In 2006/2007, CRHTs delivered 95,397 episodes of care, a shortfall of 5% from the target. However, two out every five PCTs failed to meet their target, perhaps due to a combination of factors including PCTs' spend on CRHT teams and local variations in commissioning practices and in the way teams are set up and resourced.[11] Although the national target was met as at the end of March 2008, there are still differences between PCTs in meeting their local targets for the number of home treatment episodes commissioned.

Although acknowledging that the CRHT target has served a purpose in driving improvement in CRHT implementation, the NAO has called for the development of outcomes-based metrics of performance as a replacement for the target. In support of this, for our 2008/2009

assessments of mental health services, we are planning to include an indicator on CRHT gatekeeping of admissions.

Together, our findings suggest there is more to be done to ensure that CRHT teams are fulfilling their range of functions and to a sufficient level to ensure that service users can benefit from their service.

Access to services to help people in crisis

We found that access to a range of alternatives (apart from home treatment) that could help to prevent someone in an acute crisis being admitted to hospital was limited and variable across the country. Our analysis showed that at the end of March 2007, of the catchment areas covered by the 69 mental health trusts:

Figure 11: Number of alternative acute care facilities available within the catchment area of 69 trusts

12 (17%)
31 (45%)
16 (23%)
10 (15%)

No facility   Two facilities
One facility   Three facilities
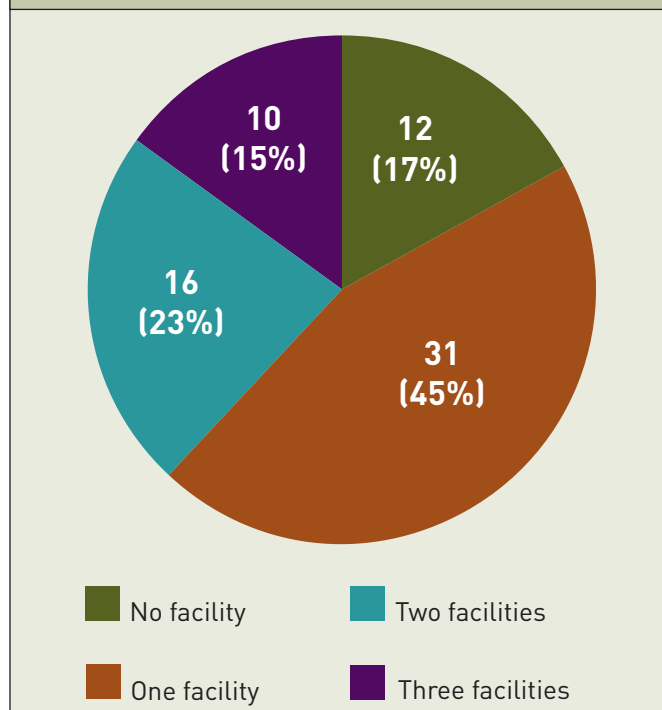
* The NAO report found that of the 189 service users discharged during the course of conducting their audit, CHRT staff had been involved in 43% of these discharges. This was reported to have resulted in earlier discharge in 85% of these cases, which would equate to nearly 37% of the discharge sample.

Table 16: The number of alternative acute care facilities available with strategic health authority catchment areas		
Strategic health authority	Number of trusts in SHA	Total number of all three types of alternatives*
East Midlands	5	8
East of England	7	9
London	9	14
North East	2	4
North West	8	11
South Central	6	6
South East Coast	3	5
South West	8	12
West Midlands	11	18
Yorkshire and the Humber	10	18
Total	**69**	**105**

* This refers to the three types of alternatives to admission included in our assessment that were available within the trust and local authority catchment areas within each SHA.

- Crisis accommodation, providing places for people in the short term, was available in 39% of areas.

- NHS day care facilities that provide a range of treatment and interventions, including components of inpatient care, were available in 65% of areas.

- Short-term breaks or respite care services, to give carers respite or a service user a break with support, were available in only 28% of areas.

- Only 15% of areas had all three facilities, while 17% had no access to any of these facilities (see figure 11).

Further analysis pointed to regional differences in the provision of alternatives to admission. The least number of alternatives were available within South Central SHA and the most within the areas covered by trusts in Yorkshire and the Humber SHA (see table 16).

The NAO report suggested that the capacity for delivering CRHT could be increased if a broader range of alternatives to hospital were available. Our findings support the case for extending the range of provision to ensure access and choice. The need for alternatives should be reviewed by local strategic partnerships and appropriate resources developed as part of a multi-agency strategy. This should inform health and social care commissioning decisions and underpin local area agreements.

National policy recommends that service users should have 24-hour access to a phone number in a crisis if they need support.[84] Our survey of mental health service users found that in 2006 only 49% of service users reported having the number of someone from their local mental health service that they could contact out of hours. In 2007, this figure had increased to 52%. In our review, the figures ranged across trusts from 23% to 86% of service users, very similar to the findings of our joint review of community mental health services. Although there has been a slight overall improvement, the wide variation between trusts remains a cause for concern.

Systems to ensure a timely and safe discharge

A stay as an inpatient should last no longer than is clinically necessary. A timely and safe discharge is underpinned by effective care planning that ensures discharge planning starts when someone is admitted to hospital. Pressures on beds can result in service users being discharged before they are ready, while inadequate capacity or resources can delay service users' return home or make the transition from hospital to home more difficult. A lack of clear protocols regarding agreed admission and discharge criteria, and the role and purpose of both CRHTs and acute inpatient care, are factors which contribute to delayed discharge.[16]

There should be effective discharge planning to enable transition from hospital to home support, in order to prevent re-occurrence of crisis and therefore re-admission.[12, 16] Of the people that committed suicide after leaving hospital between 2000 and 2004, 15% did so in the first week after discharge and 22% occurred before the person had had a follow-up visit in the community.[63] Early follow-up when someone leaves hospital is therefore critical and all patients should have face-to-face or telephone contact with community services within seven days of discharge.[85] We found that:

- Over a nine-month period, 6% of service users were re-admitted to hospital because of their mental health problem within a month of being discharged.

- In 2006/2007, 86% of people on enhanced care programme approach (CPA) were followed up within seven days of leaving hospital.*

- Over a six-month period, 6% of all the days that people spent in mental health hospitals was time when their discharge was delayed. These delays were equally caused by needing to secure accommodation or support from health and social care services to enable them to leave hospital.**

However, there were some regional variations, with accommodation issues being most problematic in the North West region and in the South East Coast. The South East was also the region with the highest average proportion of days delayed due to problems with health or social care services providing support to enable service users to leave hospital, although one trust in the South West had the highest percentage of days delayed because of health and social care factors.

* For 2006/2007, we assessed the performance of PCTs against a threshold of following up 94% service users within seven days of them being discharged from hospital – 61% of trusts met or exceeded this threshold, 16% underachieved and 23% of trusts failed to meet the threshold.

** These data were taken from the situational reports (SITREPs) data set. Accommodation factors included the following categories from SITREPS: Awaiting Care Home Placement; Residential Home; Awaiting Care Home Placement; Nursing Home; and Housing - Patients Not Covered By NHS And Community Care Act. Health and social care factors included the following categories: Awaiting Completion of Assessment; Awaiting Public Funding; Awaiting Further Non-Acute NHS Care Awaiting Care Package In Own Home; and Awaiting Community Equipment/Adaptions.

Table 17: Frequency with which community care coordinators provided input into care review meetings		
Frequency	Number out of 3,445 care records	Percentage out of 3,445 care records
All of the time	1,060	31%
Most of the time	1,248	36%
Some of the time	657	19%
None of the time	480	14%

The new Public Sector Agreement target on social inclusion (PSA 16) requires services to help the most socially excluded adults – including people with severe and enduring mental health problems – to access and maintain settled accommodation. This provides an incentive for local strategic partnerships to review and develop appropriate accommodation to meet the needs of their local population, including those being discharged from hospital. This further supports the importance of strengthening links between acute care forums and commissioner-led bodies such as local implementation teams, to ensure that local delayed discharge issues are identified and acted upon.

National policy recommends that community services and resources should be engaged at the earliest stage after admission and that there should be ongoing collaboration between inpatient and community services in assessment, delivery and discharge planning.[2] Planning for acute inpatient care should include continuity of contact with CPA care coordinators. Although the results for other care planning tasks to support the care pathway were positive, a third of all care records sampled for the review showed that community care coordinators provided input into the service user's care review meetings just "some of the time" or "none of the time" (see table 17).

With the development of a range of new specialist function teams, the level of input that care coordinators in community mental health teams can provide while service users are in hospital has become unclear. This may require further clarification to enable them to prioritise attendance at inpatient care review meetings. This should be monitored by trusts to assess the impact on the acute care pathway.

The *Refocusing of the Care Programme Approach*, due for implementation in October 2008, aims to strengthen the care coordinator's role and suggests that workload is reviewed and considered to ensure that practitioners can fulfil their functions.[25]

Workforce development

"It's the staff that make the difference in the end."

Service user and Healthcare Commission associate

A modern system of care should have at its heart a workforce that is skilled in providing the best and most effective forms of care and treatment. Nationally, there have been a number of policy and practice initiatives that have implications for the development of the mental health workforce, and that will require services to adapt systems and practices.

New Ways of Working for Everyone focuses on developing extended roles beyond the current professional remits and introducing new roles.[86] The *Creating Capable Teams Approach* aims to help multidisciplinary teams to review their skill mix and refine learning and development need on the basis of service user and carer need.[87] The current changes to mental health legislation and the refocused Care Programme Approach will have implications for workforce development.

The National Acute Mental Health Project board established a workforce subgroup to bring together the Care Services Improvement Partnership-National Institute for Mental Health in England (CSIP-NIMHE) acute care and workforce programmes. This subgroup has coordinated work to clarify and promote the implementation of workforce initiatives in acute care.

Commissioned by this group, the CSIP publication *More than just staffing numbers: A workbook for workforce development in acute inpatient care* will provide an overview of how the workforce can be developed within the context of the acute care pathway and within

the spirit of *New Ways of Working*. Other work overseen by this subgroup has been a study on the role of the consultant psychiatrist in the acute care setting.[88]

Staff capacity, competence and skill mix

There are no nationally recommended minimum staffing levels for inpatient wards, as this is influenced by a number of complex factors including ward size, physical environment, the configuration of local services, existing staff levels and local needs. Instead, national policy has advised that commissioners, the acute care forum and collaborative development networks should identify an appropriate staffing establishment that includes a sufficient number of staff with the skills and competence to provide therapeutic care.[2]

However, the CSIP-NIMHE workbook will provide practical advice on workforce redesign and planning, signposting to different approaches and examples of good practice and learning. This reiterates the need to ensure that any acute care workforce redesign is based on an assessment of local needs and considers the implications across care pathway services. We found that 93% of trusts had reviewed their staffing levels and skill mix at ward level during the previous year and that 81% had developed an action plan to address the results. This suggests that trusts are actively considering these issues. Previous work has encouraged benchmarking of services within their local system.[29]

Within our review, we used information from the 2007 adult mental health service mapping. Our consultation identified some concerns about the comprehensiveness of recording information in this data set. In an effort to improve data quality, we ensured that all the

information required from the adult mental health service mapping data set was highlighted as trusts entered the data and was included in the report that trust chief executives signed off to confirm the accuracy of the information. This was communicated to trusts through our e-bulletin to chief executives.

Based on this information, we included two indicators on the level of whole-time equivalent workforce input into the review: one in relation to acute inpatient wards, the other for psychiatric intensive care units (PICUs). We gave trusts a lower score if they were significantly below the national average in relation to their level of workforce.

None of the trusts were significantly different from the national average in relation to the workforce input on PICUs and only 11 (16%) were significantly below the national average as regards workforce input to acute inpatient wards. As might be expected, staffing ratios per bed were greater on PICU wards.

We could find no discernable difference between trust results for level of workforce input and other outcome focused indicators, such as one-to-one time with nursing staff and the availability of therapies. However, research has shown that the way staff are used may be as important as overall staff numbers, and that staff numbers may be concentrated where service users are most unwell.

This may produce an association between high staffing levels and poorer outcomes.[89]

However, the adult service mapping data suggested marked variations between the levels of core nursing staff (see table 18). Lower levels of nursing staff have been associated with more control orientated and less therapeutic wards, while higher levels have been linked with shorter lengths of stay and improved outcomes.[89]

Where there is no minimum shown in the table, it may either indicate that that there were no staff in these categories dedicated to wards within the trust, or that the relevant trust had failed to register accurately these staff types in the mapping data set.

This data set requires that staff time is apportioned as accurately as possible across service types. We would therefore expect all acute inpatient and PICU wards to have medical input apportioned, even if this were on a part-time or sessional basis, because the most common model is for at least a junior member of medical staff to be primarily on an inpatient unit and for consultants based in the community to provide two to four sessions a week to continue to oversee the care and treatment of their patients whilst in hospital.

Table 18: Level of whole time equivalent workforce input to acute inpatient wards per bed, as at 31 March 2007					
	All staff	**Nursing**	**Medical**	**Allied**	**Ancillary**
National mean	1.353	1.011	0.075	0.047	0.219
National unit mean	1.416	1.039	0.079	0.049	0.249
Minimum	0.605	0.390	-	-	-
Maximum	2.893	2.000	0.384	0.129	1.500

However, the data set shows that no medical staff time was apportioned for 38% of acute or PICU wards registered in the data set. This suggests the need to introduce further quality checks on the data entry, to ensure that the information is apportioned accurately to inform local and national workforce planning.

There has also been a longstanding issue about the low levels of multidisciplinary team input to the ward.[90] One study in 2004, based on a national sample of around a quarter of acute wards, found that a significant proportion of wards (41%) had no establishment occupational therapists and most (87%) had no dedicated clinical psychology time at all.[55] The data we used for this review indicated that, at the end of March 2007, of the registered whole-time equivalent staff for acute and PICU wards:

* 49% of wards had no dedicated occupational therapy staff.

* 79% of wards had no dedicated psychology staff.

* Few wards had dedicated pharmacists (3%), physiotherapists (4%) or art, drama or music therapists (6%).

Although this does not necessarily give us a picture of the range of interventions that service users can access in hospital, it does raise questions about the range of input from multidisciplinary teams to wards.

While recognising the need to make the best use of the workforce, the multidisciplinary team is core to *New Ways of Working for Everyone*, with an emphasis on ensuring that experienced staff work with those with the greatest needs and are available to supervise and support others. The CSIP workforce development workbook emphasises the value of the range of professional disciplines including the

contribution of psychologists in supporting the delivery of psychological therapies, occupational therapists in coordinating recovery based initiatives and pharmacists in providing specialist advice on medications and their management.

In the case of pharmacists, our medicines management review highlighted the relatively weak investment by PCTs in, or relatively low priority given by mental health trusts to, clinical pharmacy services compared to acute trusts.[22] Twenty-four per cent of mental health wards received no visits from pharmacy staff, compared to 14% in acute trusts, and only 14% of mental health wards received more than five hours of visits by pharmacy staff in a week, compared with 64% in acute trusts.

Ongoing review of skill mix among staff working on inpatient wards should include consideration of the make-up of the multidisciplinary team. In the light of the previous findings about the variable use of bank and agency nursing staff, review of capacity should also pay attention to the staffing levels required to meet needs.

Gaps in training and personal development

Previous sections of this report have identified wider training and development needs among mental health staff and emphasised the need to continue to improve access to training in diversity and the management of violence and aggression. The Delivering Race Equality cultural capability training that is being offered to mental health trusts and primary care trusts may be of benefit to inpatient staff.

Our review found that 93% had conducted an analysis of training needs in the last year. However, feedback from the plan improvement visits indicates that trusts face practical difficulties in releasing staff for training,

particularly those who are ward-based. Addressing capacity issues and introducing a wider range of training and practice development methods, such as e-learning, use of clinical supervisors or enhanced curricula, may help to address this.

As indicated, our review has strongly reinforced concerns about levels of expertise and competence in relation to working with people with specialised needs such as a dual diagnosis. There is a plethora of national policy recommending that training should be made available to all staff who routinely come into contact with people with a dual diagnosis, backed up by specialist support and supervision.[41, 78]

Similarly, we have highlighted the need to expand the provision of training programmes to support practice development in promoting sexual health and safety. The National Patient Safety Agency 2006 publication, *Safety in Mind*, provides an overview of the issues to be considered in relation to sexual safety and of good practice approaches. The CSIP-NIMHE *Informed Gender Practice* publication provides further guidance on gender sensitive practice and an advanced training module based on the *Ten Essential Shared Capabilities* due for publication in 2009 will focus on gender equality.

Our review has also highlighted training needs in supporting carers and families. Due for publication in 2008, *Closing the Triangle of Care* will highlight key strategies for raising staff awareness for engaging carers and includes a recommendation that any training developed should involve carer-trainers.

Clinical supervision and leadership development

Clinical supervision is essential to enable staff to carry out their work effectively and has been consistently advocated for ward staff.[2, 30, 36] Sixty-nine per cent of ward managers responded to our questionnaire to say that all clinical ward based staff had access to clinical supervision "all of the time" and a further 22% had access "most of the time".

This is a more positive picture than the *2006/2007 National Audit of Violence* findings, in that 40% of nurses said that they were not receiving one-to-one clinical supervision.[21] This may reflect the different perspectives on this issue and the need for local services to clarify the balance between managerial and clinical supervision. However, ensuring staff are open to, and have adequate opportunity to, reflect on their work is essential to safe practice. Practitioner support networks may also be of benefit. For example, an inpatient psychological practitioner network has been established to offer peer support to psychological practitioners working in inpatient settings, to share examples of best practice and to collaborate on relevant national initiatives.

Ward managers were also positive about the assessment and delivery of leadership training and development. Over 80% confirmed that leadership development needs had been assessed as part of their development plan in 2006/2007 and 74% that they had received the training identified. Ongoing investment in the development of managerial and leadership competencies of ward managers, charge nurses and lead consultants is important.[2, 36]

Strategic management and operational development of acute care services

Strategic focus on acute care services

Since 2002, acute care forums within trusts have been identified as the major vehicles for overseeing the strategic development of acute care services.[2] The *Capable Acute Care Forum* guidance clarified the requirements of forums.[93] Key tasks are to:

- Evaluate the strengths and weaknesses of acute care services.

- Initiate appropriate actions and encourage good practice.

- Develop joined-up care pathways.

- Create a culture of change within acute inpatient services that can be sustained.

This guidance indicates that an effective forum should be integrated with the trust's clinical governance arrangements and should build good working relationships with commissioners of services. Forums are expected to produce a report each year to evaluate the impact of their work and develop priorities for service improvement as part of an action planning process. The report and action plan should be reviewed by other key strategic management groups to ensure an integrated approach to service planning. Support from trust boards and commissioners is therefore integral to its success.

The experience of the trusts that have performed well in this assessment suggests that a well functioning and well supported acute care forum leads to better service quality and improvement. However, these trusts also suggested that refreshing this guidance would be helpful to signpost the next steps for those acute care forums that are well established.

Our review found that in the previous year, the acute care forum had developed an action plan in 88% of trusts. Of these, 95% of forums had

reviewed the plan within the last year. However, the plan had been reviewed by the trust board and local implementation teams in only a third of trusts or less. Just under half of clinical governance committees had reviewed it. This suggests that the development of acute care services may not be receiving sufficient profile at strategic levels, which may compromise their ability to effect change.

Poor results in the review and selection for a follow-up visit had led, in most of the trusts we visited, to strategic managers raising the profile of inpatient services, particularly at trust board level. However, most of the visit reports included reference to the need to sustain this, and to ensure that the appropriate infrastructure and governance arrangements were developed to support it. Strengthening the acute care forum was identified as central to this process.

Involvement of commissioners

National guidance recommends that the acute care forum should include the following membership: frontline ward staff, senior designated leads from each of the key professional groups, mental health commissioners, representatives of community acute care services, voluntary and advocacy groups, service users and carers.[93]

We looked at the attendance of certain key stakeholders in at least half of the forum meetings within the previous year. This showed that frontline ward staff most often attended forum meetings, with representatives of community acute care services and key professional leads not far behind. Four out of five trusts reported regular attendance of service users and just under two-thirds reported carers attending at least half of all acute care forum meetings held in the previous year.

Table 19: Proportion of key stakeholders that attended at least half of all acute care forum meetings in the previous year	
	Percentage of 68 trusts
Frontline ward staff	97%
Senior designated leads from key professional groups	88%
Representatives of community acute care services	88%
Service users	81%
Carers	62%
Mental health commissioners	18%

The involvement of commissioners in these meetings was significantly lower. Less than one in five trusts reported regular attendance by commissioners (see table 19).

This raises questions as to how effective commissioners' links are with their local acute care forum. Since 2003, the Healthcare Commission has assessed the performance of PCTs in relation to their commissioning of home treatment episodes. Active links with the relevant acute care forum would ensure that commissioning decisions about the range of acute care services were based on relevant and current information to help them achieve this target.

Involving service users in operational and strategic monitoring and development

Service users should be involved in planning what happens on the ward[2, 28, 30] and in wider operational and strategic monitoring and development. Within our review, we explored their involvement at these different levels. At ward level, over a six-month period, 70% of wards indicated they had held community meetings at least weekly to seek feedback from service users about the day-to-day running of the ward. Although around 60% of ward managers reported that these meetings had some degree of independent facilitation, only 15% indicated that these meetings were independently facilitated "all of the time". Independent facilitation, for example by an advocacy service or a service user led group, may help to ensure that service users feel comfortable in expressing their views and concerns and that there is an objective mechanism through which issues can be raised.

Although there was variation between trusts, our review showed that access to independent advocacy was well established and that other involvement structures, such as patient advice and liaison services (PALS), were in place (see figure 12 overleaf). Other more strategic methods of involving service users were less well developed, particularly the involvement of service users in audit and monitoring, staff recruitment and training, although these methods were in use in over half of acute wards nationally.

Figure 12: Methods of involving service users in monitoring and developing services on 554 wards
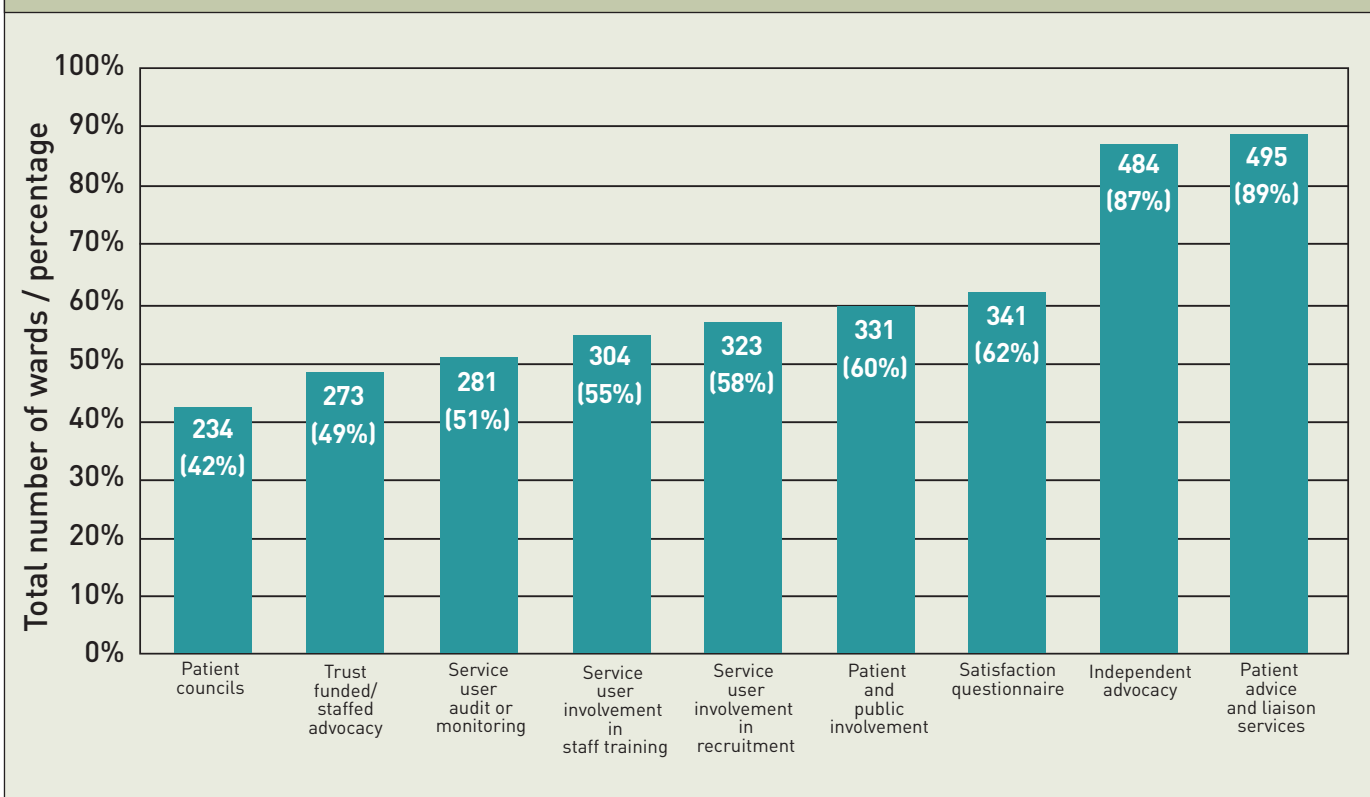
Using information to monitor service provision

Our results showed that almost a fifth of trusts (19%) had completed all eight audits we asked about in the last year. A further quarter of trusts had completed seven of these audits.

Implementation of National Institute for Health and Clinical Excellence (NICE) guidelines was least often audited (see table 20). Developing an action plan and sharing learning across the trust to complete the audit cycle was less often done, but was still relatively high for most audits. These results were encouraging in relation to the monitoring of key issues at the local level. In sustaining this, it is important that trusts develop an audit programme that spans the acute care pathway.

However, the plan improvement teams identified problems with the availability of robust data in some trusts to enable ongoing monitoring of services, and with the communication systems to ensure the dissemination of learning to front line staff. In some instances, this reflected a lack of comprehension about the most appropriate information to monitor on an ongoing basis.

We would therefore encourage acute care forums, trust boards and clinical governance committees to use the results from this review as a benchmark for monitoring local progress, and commissioners to incorporate aspects of the assessment framework with their

Table 20: Reviews or audits at ward level carried out (and audit cycle completed) within the previous year				
Audit	Number of trusts where the audit was identified as appropriate*	Percentage of trusts where audit was conducted	Where conducted, the percentage of trusts where action plans were NOT developed	Where conducted, the percentage of 68 trusts where learning was NOT shared
Levels of polypharmacy	68	81%	12%	7%
Use of rapid tranquilisation	67	82%	2%	14%
Implementation of NICE guidelines	68	78%	4%	12%
Use of seclusion	50	86%	15%	9%
Levels of observation	68	84%	16%	6%
Staffing levels/skill mix	68	93%	11%	2%
Training needs analysis	68	93%	8%	7%
Provision of activities	68	91%	5%	7%

*Trusts were able to indicate that "use of rapid tranquillisation" and "use of seclusion" were not used so that conducting audits about these practices would not have been appropriate. Therefore, the number of trusts that could have conducted these two audits in the previous year was lower as a result.

commissioning contracts as a basis for evaluating performance. The bespoke data collection tools are available on our website and can be re-used at any time. These tools could also be adapted for use in other settings, for example in relation to acute inpatient services for older adults with mental health problems and independent sector providers.

However, it may also be helpful to build in the learning from this review and examples from the field of information that is routinely used to monitor acute care service provision to produce indicator sets for both local and national use by service providers and commissioners to assess progress.

What makes the difference?

Understanding what helps to develop high quality acute care services is important to improving and sustaining progress. This section summarise the key factors that emerged from the 'success factors' event and the plan improvement visits that support or hinder the development of high quality services.

Factors supporting the development of high quality acute care services

All trust representatives who took part in the success factors event reported that their trust had reviewed and modernised their inpatient services at least a year or two earlier than the review. The incentives to modernise varied but included:

- Wider service reconfiguration or whole systems review.

- Securing funding to support modernisation.

- Poor feedback from service users and carers.

- Recognition of a gap between senior management and frontline ward staff.

- Opportunities associated with introducing new services and opening new inpatient units.

- New national policies or guidance.

Attention to service modernisation
Often the modernisation process involved:

- Devising a strategic plan for development with a clear sense of purpose and setting measurable objectives linked to national standards.

- The acute care forum acting as the key driver and mechanism for monitoring change and progress.

- Appointing or identifying skilled staff to lead development processes who were given dedicated time and freedom to act.

- Engagement of all key stakeholders including clinicians, service users and carers as key partners in the change process.

- Provision of staff training or investment in customer care.

- In some cases, dismissing or changing senior staff or recruitment of new staff with different skills.

- Identifying where skills were best placed or the reallocation of roles and responsibilities.

- Developing performance management structures and frameworks.

- Participating in a quality improvement initiative such as the Accreditation for Acute Inpatient Mental Health Services (AIMS) from the Royal College of Psychiatrists' Centre for Quality Improvement.

Developments were focused on particular aspects of their acute care services, such as moving from a generalist service configured around localities to a specialist-based service, improving the ward or unit environment, changing the structure of ward rounds, developing care planning processes, refocusing the role of the primary nurse or introducing a new practice model. All participants emphasised the importance of seeing the acute care pathway as a whole within which inpatient services are a core element. This approach was seen as key to service development.

Organisational culture and readiness to embrace change
Some of these trusts have a strong culture of continuous service improvement based on a proactive approach to change. Within this,

participants cited leadership as crucial to success, particularly leaders who can engage and inspire.

There was clear evidence that successful trusts had well-established audit and robust governance processes, with relatively effective feedback and communication systems that ensured clarity of purpose, understanding of roles and responsibilities and staff being held to account if they did not deliver against objectives.

Participants expressed a sense of pride about their local inpatient services and an acknowledgement that confidence in the inpatient service had been rebuilt such that their wards were now places where staff were keen to work. This was contrasted with the loss of inpatient staff and skills when the new community teams were introduced. Creating effective links between management and frontline staff was also seen as an important influence. Examples of this included senior or operational managers 'walking the wards' on a regular basis, working shifts or having regular, direct contact with frontline staff and service users.

Seminar participants also identified the positive impact of bringing professionals from different disciplines together, improving team work, engaging frontline staff in undertaking audit and achieving better retention of staff, which has strengthened the skills among the inpatient teams.

There was an acknowledgement of the value of quality improvement, collaborative and networking initiatives, independent service review, and external accreditation or peer audit in supporting the development process. For some trusts, preparation for foundation trust status had provided an impetus to enhance local governance structures that were seen to

support service developments with acute care services.

The role and status of the acute care forum
The role and status of the acute care forum (ACF) was seen as an important lever for change. Particular lessons had been learnt in relation to maintaining high level support for the ACF. In one of the larger trusts, local forums had been established to ensure a focus on issues that mattered most within each locality. However, these local forums had lost direction, so the introduction of a trust-wide ACF had helped to coordinate activity and resulted in a clearer reporting structure.

Other trusts identified having the right membership, including staff with seniority and authority involved, and having good links with strategic decision-making groups as helping to ensure appropriate action is taken and sufficient profile given to acute care services within the wider service agenda.

Involvement of service users and carers
The involvement and engagement of service users and carers in developing processes was seen as key, particularly as a way to ensure that acute care services were focused around the needs of the service user as opposed to the needs of the service.

Approach to this service review
Seminar participants indicated that their trusts had dedicated resources to preparing for this service review. In some cases, this offered an opportunity for re-energising work in relation to the inpatient setting. Some reported that their trust had assessed itself against the indicators in the draft assessment framework for the review when this was published, or had formed working groups to coordinate and manage the data collection process within the trust.

Challenges to sustaining quality of acute care services

Participants at the success factors event identified a number of key challenges to sustaining the quality of acute care services. They expressed concerns that:

- A pervading risk averse culture stifled practice and service development within the inpatient setting. The focus on incidents, absconding and bureaucratic processes hindered progression of more positive aspects and opinions of inpatient care.

- The quality of commissioning needs to be improved, particularly the sophistication of assessment of local need for acute care services to ensure they are given sufficient priority. Investment in services needs to be informed with a clear understanding of the overall care pathway, and within the development of an appropriate performance management framework for these services.

- Financial deficits hindered improvement of acute inpatient services, which were too often seen as target areas for savings, while additional investment was needed to develop the environment and to build sufficient quality and capacity within the inpatient setting.

Factors hindering the development of acute care services

To some extent, the factors hindering the development of high quality acute care services are the corollary of those support factors we have identified above. The lessons that emerged from the plan improvement visits suggest that the following factors need to be considered by those organisations wishing to develop their services.

These issues applied in varying degrees to the organisations we visited, where there was a general sense of commitment to service improvement. Poor performance on this service review has meant that acute inpatient services have been given greater attention at trust board level and, as relevant, by strategic health authorities or Monitor. This is a positive change that needs to be built on.

Lack of strategic direction

Within those trusts that had performed least well, the plan improvement visits raised questions about the strategic direction for acute care services. There was either a lack of a developed strategy or a dissonance between the strategy for the services and the reality on the ground as experienced by frontline staff, service users and carers. In some trusts, the lack of a strategy for service user or carer involvement was also linked to poor outcomes in these areas.

In some cases, the lack of strategic direction was linked to mergers that had taken place in the preceding year or so before the review. In others, competing priorities or needing to address financial deficit had contributed to a weakened focus on acute care services. In certain trusts, the visits pointed to a failure among senior managers and commissioners to understand the acute care pathway and, in particular, what information they needed to monitor service provision and measure progress. While information was routinely collected from the wards, this was not being used effectively to inform decision-making, nor was it fed back to frontline staff.

The plan improvement reports frequently recommended the development of infrastructure and governance arrangements to enable the strategic development of acute care services. For health and social care

commissioners, this means supporting and taking an active interest in their local acute care forum, ensuring that acute inpatient service provision is based on robust assessment of local need and an understanding of existing provision within the context of the whole system, taking account of poor estates issues and focusing on service user outcomes.

Although some of these trusts had developed action plans following the release of the provisional review scores, there was limited evidence that change processes had been started. The action plans were often aspirational but not always comprehensive in addressing all of the deficits identified through the assessment, nor in taking a whole systems approach to identify and address key underlying workforce and organisation issues that contributed to the poor overall score.

The acute care forums were not always working effectively, often due to limited attention and support from the trust board, commissioners and other strategic decision-making groups, not having all key stakeholders involved and with insufficient authority action to address problems identified.

Lack of effective communication
The plan improvement visits identified pockets of good practice, particularly in the larger trusts. However, ward isolation and silo working were also evident, as was a lack of a streamlined communication system required to ensure effective sharing between wards and between frontline services and senior management. Communication problems were both evident within the organisations, and between the trust and external agencies such as local authorities and relevant community organisations.

In some trusts, cultural differences between wards and variations in ward practices were linked to general organisational culture, most notably readiness for change, geographical dispersion, poor planning and coordination.

Lack of whole systems thinking
Difficulties in relation to the effective operation of wider practice systems were also apparent including care coordination systems, assessment and care planning processes and communication between mental health teams. This often reflected a lack of whole systems thinking and a lack of clarity about the acute care pathway and about workforce redesign.

Within acute care services, crisis resolution home treatment (CRHT) teams were continuing to receive, or were focusing on, inappropriate referrals that affected their capacity to deliver the core service. The understanding of the CRHT's role and the capacity within primary care services to triage people during a crisis and a lack of alternatives to hospital admission also impeded the effectiveness of the care pathway. This was compounded in circumstances where the roles of existing community mental health teams had not been clearly redefined as crisis services had been developed.

Ineffective ways of working
Ineffective multi-disciplinary working, lack of clinical leadership, resistance to introducing new approaches to working and reliance on 'overly' traditional medical models were identified as hindering the development of focused acute inpatient services. On the other hand, in circumstances where staff within the multi disciplinary team were inexperienced, lacked confidence or were unwilling to assume authority for decision-making, leadership responsibility often fell to the consultant psychiatrist.

Staff attitudes and ward culture
Feedback from service users pointed to negative staff attitudes and inadequate customer care as significantly contributing to an unsatisfactory experience of an inpatient admission. They identified the staff and the culture that was developed in the wards as making the most difference to them. In some trusts, middle managers were aware of difficulties at the ward level but were not communicating these upwards. In others, frontline staff were keen to develop services but were not sufficiently empowered to do so.

The plan improvement visits also highlighted the need for further workforce training and development, the need to improve the physical environment and to develop practice in some areas to better ensure the quality, safety and effectiveness of service delivery.

Conclusions

A number of conclusions can be drawn from the key findings of this report, not least the fact that acute inpatient wards remain a vital component of the acute care pathway. This review has taken place in the context of other national work on acute care, with a focus on improvement in the quality and safety of services.

The evidence suggests that the renewed policy focus on acute care services, together with 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.

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.

There were differences in the distribution of the overall scores by type of trust. The trusts that had become foundation trusts at the time we conducted 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 of the relatively small number of trusts in the review. However, these results do suggest that the

larger the trust, the greater the challenge in achieving consistent standards across all wards. Commissioning of acute care services also needs to take account of the particular challenges faced by those larger trusts serving an urban, more deprived population to ensure delivery of a quality service.

In addition to wide variations between trust performance on a number of indicators, our review has also identified marked differences between wards within trusts in relation to the quality of acute inpatient services provided. This is a cause for concern because of the impact it has on the experience of service users and carers but also it fails to provide the consistency that is required around the quality and safety of acute care services across the country.

The results have shown that there is scope for improvement across all services that have participated and the recommendations need to be considered by all in the context of their local service. 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.

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 (BME) groups. We have particular concerns that the views of people from BME 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 BME 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 BME 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. Our review found that 16% of trusts were significantly above the national average in 2006 (11%) in relation to the recorded rate of assaults on service users. 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 that care and treatment is individualised and personalised, and, responsive to local needs by:

- 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.

Appendix A: Framework of assessment

The figure below outlines the framework of assessment, showing the four criteria that contributed to the overall score, and the questions included in each criteria level.

Overall score:

Admissions to acute inpatient mental health services are appropriate, purposeful, therapeutic and safe

Criterion one:
There is an effective care pathway that ensures admission to hospital is appropriate and that discharge from hospital is timely

Questions relating to criterion 1:
- Appropriate admissions, with involvement from the crisis resolution home treatment team
- Effective care planning
- Timely discharge, with involvement from the crisis resolution home treatment team
- Governance and monitoring of acute care pathway

Criterion two:
Inpatient services provide individualised whole person care that promotes recovery and inclusion

Questions relating to criterion 2:
- Access to staff and interventions
- Physical health
- Social inclusion
- Care appropriate to individual needs

Criterion three:
Service users and carers are involved in care planning, in how the ward is run and in operational and strategic planning, evaluation and development

Questions relating to criterion 3:
- Provision of information
- Involvement in care planning
- Involvement in operational and strategic planning

Criterion four:
The ward has systems, processes and facilities in place to ensure the safety of service users, staff and visitors

Questions relating to criterion 4:
- Safety of staff, service users and visitors
- Infrastructure to promote safety
- Positive therapeutic environment

Appendix B: Data collection

We used national data sources as far as possible to minimise the burden of additional data collection upon trusts. We used the most up-to-date available data set, and in most cases this related to 2006/2007. However, when we piloted our assessment, we found that the available national data did not always provide us with information that was specific enough to capture the complexities of acute care services and so we asked trusts to complete a bespoke data collection for the assessment.

The bespoke data collection for the review had four elements:

- A questionnaire for acute inpatient leads

- A questionnaire for ward managers

- A questionnaire for service user groups

- An audit of care records.

When we developed the assessment framework, we had hoped to be able to incorporate data from a national survey of inpatients to assess trust performance. However, the feasibility testing of the survey highlighted problems in securing a sufficient sample as a basis for comparing performance, which meant that the national roll out of the survey was delayed. In view of this, we decided to ask trusts to involve representatives of service user groups in collecting data for the review as an alternative means of including the views of service users in the performance assessment.

As table 21 shows, trusts were able to coordinate the data collection and submission of all service user group questionnaires for the review.

Table 21: Bespoke data collection submission rates			
	Forms expected	**Forms returned by submission deadline**	**Submission rate**
Questionnaire for acute inpatient leads	69	68	99%
Questionnaire for ward managers (completed for each relevant ward)	554	551	99%
Questionnaire for service user groups (completed for each relevant ward)	554	554	100%
Audit of care records (completed for a sample of 50 care records)	3,450	3,450	100%

Appendix C: Overall performance of trusts against individual assessment questions

Distribution of question scores for the 69 mental health trusts

Criterion 1: there is an effective care pathway that ensures admission to hospital is appropriate and that discharge from hospital is timely				
Question theme	**"Weak"**	**"Fair"**	**"Good"**	**"Excellent"**
Q1 Effective integrated care pathway to ensure that admissions are appropriate	10%	59%	25%	6%
Q2 Care planning processes to support the care pathway	17%	32%	38%	13%
Q3 Effective integrated care pathway to ensure that discharge from hospital is timely	19%	67%	14%	0%
Q4 Governance and monitoring arrangements in place	13%	43%	35%	9%

Criterion 2: inpatient services provide individualised whole person care that promotes recovery and inclusion				
Question theme	**"Weak"**	**"Fair"**	**"Good"**	**"Excellent"**
Q1 Access to staff and to a range of interventions	3%	45%	43%	9%
Q2 Addressing physical health needs	38%	22%	29%	12%
Q3 Promoting social inclusion	23%	42%	29%	6%
Q4 Care and support appropriate to individual needs	3%	54%	42%	1%

Criterion 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				
Question theme	**"Weak"**	**"Fair"**	**"Good"**	**"Excellent"**
Q1 Availability of information to service users and carers	28%	29%	22%	22%
Q2 Involvement in decisions about care and treatment*	58%	26%	12%	4%
Q3 Involvement in operational and strategic development	19%	30%	25%	26%

* The indicator in this question concerned with the views of service users being included on the most recent care plan was given more weight than all the other indicators in the review. We automatically scored a trust as "weak" for the question if we scored them "weak" for this indicator.

Criterion 4: the ward has systems, processes and facilities in place to ensure the safety of service users, staff and visitors				
Question theme	**"Weak"**	**"Fair"**	**"Good"**	**"Excellent"**
Q1 Safety of staff and service users is ensured	3%	58%	33%	6%
Q2 Infrastructure in place that promotes safety	20%	61%	19%	0%
Q3 Positive therapeutic environment	6%	39%	42%	13%

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Herefordshire Primary Care Trust

Kent and Medway NHS and Social Care Partnership Trust

North East London Mental Health NHS Trust*

Northumberland, Tyne and Wear NHS Trust

Nottinghamshire Healthcare NHS Trust

Portsmouth City Teaching Primary Care Trust

Somerset Partnership NHS and Social Care Trust*

Surrey and Borders Partnership NHS Trust*.

* This was the name of the trust at the time of conducting the pilot, before it achieved foundation trust status.

References

1. Department of Health, *A National Service Framework for Mental Health*, 1999

2. Department of Health, *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*, 2002

3. Department of Health, *Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units and Low Secure Environments*, 2002

4. Mental Health Act Commission, *In Place of Fear? Eleventh Biennial Report, 2003-2005*, 2005

5. Commission for Social Care Inspection and the Healthcare Commission, *No voice, no choice: A joint review of adult community mental health services in England,* 2007

6. Department of Health/Mental Health Strategies, *The 2006/07 National Survey of Investment in mental health services*, 2007

7. Department of Health, NHS reference costs 2006-07, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance /DH_082571

8. Appleby L, *The national service framework for mental health – five years on*, Department of Health, 2004

9. Healthcare Commission, *Count me in 2007*

10. Mental Health Act Commission, *Rights, Risks and Recovery. Twelfth Biennial Report, 2005-2007*, 2008

11. National Audit Office, *Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services*, 2007

12. See for example:

    King's Fund, *London's State of Mind: King's Fund Mental Health Inquiry* 2003

    Norfolk, Suffolk and Cambridgeshire SHA, *Independent Inquiry into the death of David Bennett*, 2003

    Mind, *Ward Watch: Mind's campaign to improve hospital conditions for mental health patients*, 2004

    Rethink, *Future Perfect: Mental Health service users set out a vision for the 21st century*, 2005

    Sainsbury Centre for Mental Health, *Acute Care 2004: A national survey of adult psychiatric wards in England*, 2005

    Mental Health Act Commission, *Who's been sleeping in my bed? The incidence and impact of bed over occupancy in the mental health sector*, 2006

13. Care Services Improvement Partnership (CSIP) – National Institute for Mental Health in England (NIMHE), *Onwards and Upwards*, 2007 www.nimhe.csip.org.uk/silo/files/onwardsandupwardshandbookpdf.pdf

14. www.nimhe.csip.org.uk/~virtualward/

15. http://starwards.org.uk/

16. Care Services Improvement Partnership (CSIP) – National Institute for Mental Health in England (NIMHE), *A Positive Outlook: A Good Practice Toolkit to Improve Discharge from Inpatient Mental Health Care*, 2007

17. North East London Mental Health NHS Trust, *STEPS: successful team engagement in inpatient psychiatric services*, 2007

18. Care Services Improvement Partnership (CSIP) – National Institute for Mental Health in England (NIMHE), *Informed Gender Practice – mental health acute care that works for women*, 2008

19 Care Services Improvement Partnership (CSIP) – National Institute for Mental Health in England (NIMHE), *Laying the foundations for better acute mental healthcare*, 2008

20. The Royal College of Psychiatrists' Research Unit, *The National Audit of Violence (2003-2005) Final Report*, 2005

21. Royal College of Psychiatrists' Centre for Quality Improvement, Healthcare Commission *National Audit of Violence. Final report - working age adults 2006/7*, 2008

22. Healthcare Commission, *Talking about Medicines: the management of medicines in trusts providing mental health services*, 2006

23. Healthcare Commission, *State of Healthcare 2007*

24. Department of Health, *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach*, 1999

25. Department of Health, *Refocusing the Care Programme Approach. Policy and Positive Practice Guidance*, 2008

26. National Institute for Mental Health in England, *NIMHE Guiding Statement on Recovery*, 2005

27. Department of Health, *Code of Practice: Mental Health Act 1983*, 1999 and 2008

28. Janner M, *Star Wards*, Bright, 2006

29. Ryan T, Hills B and Webb L, "Nurse Staffing Levels and Budgeted Expenditure in Acute Mental Health Wards: A Benchmarking Study" *Journal of Psychiatric and Mental Health Nursing*, 2004 (11) 73-81

30. Department of Health, *From Values to Action: The Chief Nursing Officer's Review of Mental Health Services*, 2006

31. Care Services Improvement Partnership (CSIP) – National Institute for Mental Health in England (NIMHE), *Our Choices in Mental Health: Improving Choice for People who Use Mental Health Services*, 2005

32. Department of Health, *The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce*, 2004

33. Department of Health, *Essence of Care: Patient-Focused Benchmarks for Clinical Governance*, 2003

34. National Institute for Mental Health in England, *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*, 2003

35. SHIFT/National Institute for Mental Health in England, *Healthy Body, Healthy Mind: Promoting Healthy Living for People Who Experience Mental Health Problems: A Guide for People Working in Inpatient Services*, 2004

36. Royal College of Psychiatrists, *Accreditation for Acute Inpatient Mental Health Services (AIMS)*, 2006

37. Wales Collaboration for Mental Health, *Under Pressure: Report of the Risk and Quality Review of NHS Mental Health Services*, 2005

38. Mental Health Act 2007, www.opsi.gov.uk/acts/acts2007/ukpga_200 70012_en_1

39. Department of Health, *The NHS in England: The operating framework for 2008/9*, 2007

40. Department of Health, *Green Light for Mental Health: How Good are Your Mental Health Services for People With Learning Disabilities. A Service Toolkit*, 2004

41. Department of Health, *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings: Guidance on the Assessment and Management of Patients with Mental Health Inpatient and Day Hospital Settings*, 2006

42. Department of Health and Care Services Improvement Partnership, *Everybody's Business: A Service Development Guide*, 2005

43. National Institute for Clinical Excellence, *Antenal and Post Natal Mental Health: Clinical Management and Service Guidance*, 2007. Lewis, G (ed), *The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer – 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom*, CEMACH, 2007

44. TNS UK for the Care Services Improvement Partnership, Department Of Health, *Attitudes To Mental Illness 2008 Research Report*, 2008

45. Appleby L, *Breaking down barriers – the clinical case for change*, Department of Health, 2007

46. Social Exclusion Unit, *Mental Health and Social Exclusion*, Office of the Deputy Prime Minister, 2004

47. Janner M, *Star Wards 2: The Sequel*, Bright, 2006

48. Scott S, Robinson B and Day C, *Parents in Hospital: How Mental Health Services Can Best Promote Family Contact When a Parent is in Hospital*, Care Services Improvement Partnership, Mental Health Act Commission, Barnardos and Family Welfare Association, 2007

49. Department of Health, *Choosing Health: Making Healthy Choices Easier*, 2004

50. National Institute for Clinical Excellence, *Violence: The Short-Term Management of Disturbed/Violent Behaviour in Psychiatric In-Patient Settings and Emergency Departments*, 2005

51. Mental Health Act Commission, *Who's Been Sleeping in My Bed? The Incidence and Impact of Bed Over-Occupancy in the Mental Health Acute Sector*, 2006

52. Royal College of *Psychiatrists, Psychiatric beds and resources: Factors influencing bed use and service planning*, 1998

53. National Institute for Mental Health In England, *Assessing Physical Environmental Deficits in Units Which Manage People with Mental Health Problems Who Present With Challenging Behaviours*, 2004

54. Department of Health, *Mental Health Policy Implementation Guide: Developing positive practice to support the safe and therapeutic management of aggression and violence in mental health inpatient settings*, 2004

55. Sainsbury Centre for Mental Health, *Acute Care 2004: A national survey of adult psychiatric wards in England*, 2005

56. National Patient Safety Agency, *With Safety in Mind: Mental Health Services and Patient Safety. Patient Safety Observatory Report 2*, 2006

57. Department of Health, *Women's Mental Health: Into the Mainstream*, 2002

58. Department of Health, *Safety, Privacy and Dignity in Mental Health Units*, 2000

59. Department of Health, Executive Letter EL (97)43, 1 January 1997

60. Department of Health, *Privacy and Dignity: A Report by the Chief Nursing Officer into Gender Mixing in Hospitals*, 2007

61. www.dh.gov.uk/en/Publicationsandstatistics /Lettersandcirculars/Dearcolleagueletters /DH_074004

62. Bowers L, Jarrett M, Clarke N, Kiyimba F and McFarlane L, "Absconding: Outcome and risk, part 3". *Journal of Psychiatric and Mental Health Nursing* 1999, 6, 213-218.

63. Appleby L, Shaw J, Kapur N, Windfuhr K, Ashton A, Swinson N and While D, *Avoidable Deaths: The five year report of the national confidential inquiry into suicide and homicide by people with mental illness*, University of Manchester, 2006

64. www.citypsych.com/ Further information about the research underpinning this can be found at: www.nimhe.csip.org.uk/silo/ files/runaway-patientspdf.pdf

65. Bowers L, Hackney D, Nijman, Grange A, Allan T, Simpson A, Hall C, Eyres S, *A Longitudina Study of Conflict and Containment on Acute Psychiatric Wards*, City University London, 2007

66. Royal College of Psychiatrists, CR138: *Consensus Statement on High-Dose Antipsychotic Medication*, 2006

67. British National Formulary No. 54, 2007

68. Taylor D, Paton C, Kerwin R, *The Maudsley Prescribing Guidelines 9th edition*, Informa Healthcare, 2007

69. Connolly A and Taylor D, "Antipsychotic prescribing quality and ethnicity in hospitalised patients in South London", 2008 (in press, *British Journal of Psychiatry*).

70. TSO, *The Mental Capacity Act*, 2005

71. Disability Rights Commission *Equal Treatment: Closing the Gap. A Formal Investigation into Physical Health Inequalities Experienced by People With Learning Disabilities and/or Mental Health Problems,* [need date 2006 or 2007?]

72. National Institute for Clinical Excellence, *Depression: Management of Depression in Primary and Secondary Care*, 2004

73. National Institute for Clinical Excellence, *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care*, 2002

74. National Institute for Clinical Excellence, *Guidance on the Use of Electroconvulsive Therapy*, 2003

75. The ECT Accreditation Service (ECTAS), *Standards for the administration of ECT*, The Royal College of Psychiatrists' Research Unit, 2005

76. Royal College of Nursing, *Nursing Guidance for ECT*, 2005

77. Department of Health, *Mainstreaming Gender and Women's Mental Health: Implementation Guidance*, 2003

78. Department of Health, *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*, 2002

79. See for example: Weaver T, Charles V, Madden P and Renton A, *Co-morbidity of substance misuse and mental illness collaborative study (COSMIC): A study of the prevalence and management of co-morbidity amongst adult substance misuse and mental health treatment populations*, Imperial College of Science, Technology and Medicine, 2002

    Phillips P and Johnson S, "Drug and alcohol misuse among inpatients with psychotic illnesses in three inner London psychiatric units", *Psychiatric Bulletin*, 2003, 27: 217-220

80. Care Services Improvement Partnership, *Themed Review Report 07: Dual Diagnosis*, 2008
    www.csip.org.uk/resources/publications/dual-diagnosis.html

81. Hughes E, *Closing the Gap: a capability framework for working effectively with people with combined mental health problems and substance misuse problems (dual diagnosis)*, CCAWI, Lincoln, 2006

82. See for example: Osher F and Kofoed L, "Treatment of patients with psychiatric and psychoactive substance abuse disorders", *Hospital and Community Psychiatry*, 1989, 40: 1025-30

    Drake R et al, "Implementing dual diagnosis services for clients with severe mental illness", *Psychiatric Services*, 2001, 52: 469-76.

    Graham H L, *Cognitive-Behavioural Integrated Treatment (C-BIT): A treatment manual for substance misuse in people with severe mental health problems*, Wiley, Chichester, 2004

83. Morgan C et al, "Pathways to care and ethnicity. Source of referral and help seeking. Report from the AESOP study", *British Journal of Psychiarty*, 2005, 186: 290-6

84. Department of Health, *Mental Health Policy Implementation Guide,* 2001

85. Northern Centre for *Mental Health, Mental Health Collaborative Project Improvement Measures*, 2000

86 Department of Health, *Mental Health: New Ways of Working for Everyone, Developing and sustaining a capable and flexible workforce*, 2007

87 Department of Health, *Creating Capable Teams Approach*, 2007

88. Middleton H, Baguley I, Alexander J and Bell L, "The Role of Consultant Psychiatrist in the Acute Care Setting: A report to the Acute Inpatient Mental Health Project Board from the Acute Care Workforce sub-group" (unpublished paper, 2008)

89. Bowers L and Flood C, Parkin D, "Nurse staffing, bed numbers and the cost of pscychiatric inpatient care in England" (in press, *Journal for Psychiatric and Mental Health Nursing*)

90. National Institute for Mental Health In England, *The Capable Acute Care Forum*, 2004

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