



# SCOTTISH EXECUTIVE

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Dear Colleague

## **NHS HDL (2006) 64 DELIVERING FOR MENTAL HEALTH: ACUTE INPATIENT FORUMS (AIFs)**

You will have seen the above HDL announcing the immediate forward agenda for mental health services in Scotland. That letter and *Delivering for Mental Health*, which was enclosed, set out key targets and commitments for NHS Boards and partners to at least 2010. This letter offers further background and next steps detail on the commitment to establish Acute Inpatient Forums (AIFs) within each NHS Board area.

I attach guidance for your information on how AIFs will be structured, run and held accountable. Also enclosed is a copy of a report produced by a short-life working group for which particular thanks go to Dr Tom Brown, Chair of the Royal College of Psychiatrists and Hugh Hill, Director of Services and Strategy of the Scottish Association for Mental Health. The guidance and the report are also available at:

<http://www.scotland.gov.uk/Topics/Health/health/mental-health/servicespolicy/latest>

In summary, NHS Board Chief Executives will be responsible for the establishment of Acute Inpatient Forums and how they function. AIFs action will be monitored through an enhanced performance management system to be in place by March 2007 and there will be an opportunity for dialogue with SEHD colleagues through a rolling visiting programme. As matters progress I will be in touch with your appointed Joint Local Implementation Coordinator. These arrangements will build on existing visiting, monitoring and other processes and will be designed to engender a positive experience for all concerned in delivering the *Delivering for Mental Health* targets and commitments.

Once established, AIFs will help support and drive the delivery of a number of other commitments and targets within *Delivering for Mental Health*. Specifically the aim is for the AIF in each area (and collectively) to give focus, help and support to delivering the target to reduce the number of readmissions (within one year) for those that have had a hospital stay of over 7 days by 10% by the end of December 2009.



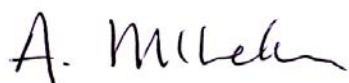
In terms of the wider contribution to be made, the AIFs will also have an important role to play in ensuring that all units and wards provide an appropriate physical and therapeutic environment for those who need care and treatment. They will also help advance the commitment (number 11) to reduce the number of inappropriate admissions of children and young people to adult beds.

In HDL (2006) 64 Kevin Woods mentioned a range of initiatives designed to support *Delivering for Mental Health* and underlined the importance of linking, where appropriate, to other initiatives underway and planned. With various commitments in mind I encourage you and your colleagues to contact Suzanne Forrest at NHS Education for Scotland particularly in relation to the educational element of the implementation of the Mental Health Nursing review. Work is already underway on the need to establish Networks for practice development in acute care.

Simon Bradstreet at the Scottish Recovery Network is working with NHS Education for Scotland to take forward the recovery agenda. That overall agenda links well with the key *Delivering for Mental Health* commitment (number 1) on developing and piloting a tool to assess organisations and programmes in respect of equality, diversity, social inclusion and recovery. This work, together with the development of a Peer Support Worker course and the piloting of this role in 2008, provides a significant opportunity to review and improve quality of care. It also provides an opportunity to learn from the experience that individuals receive when they need to be admitted to an acute inpatient setting. Staff motivation and development will also require and receive attention as part of this agenda.

Your help in advancing the *Delivering for Mental Health* commitments and targets is appreciated and I look forward to working with you and your colleagues on this priority over the coming period.

Yours sincerely



**ALEX MCMAHON**

Head of Mental Health Delivery and Services Unit

## **GUIDANCE ON THE STRUCTURE OF THE ACUTE INPATIENT FORUM**

The report of the Delivering for Mental Health: Psychiatric Inpatient Facilities Working Group was produced in September 2006 for the Delivery Group producing the Scottish Executive's Mental Health Delivery Plan.

That report recommended the creation of Acute Care Forums (a minimum of 1 forum in each health board area), similar but not identical to, those described in the Department of Health Mental Health Policy Implementation Guide in England. It is recommended that this guidance be read in conjunction with the September 2006 report as this contains more detailed guidance on the role of what are now termed Acute Inpatient Forums.

### **Membership**

The membership of the Acute Inpatient Forum should be representative of key clinicians involved in delivering acute in-patient care, local authority partners, voluntary organisations and service users and carers. One of the first tasks of the forum will be to clarify the roles of its members and in particular how they will communicate with those they represent. It is also imperative that the Forum builds on existing strategic planning structures and integrates with these.

It is suggested that the following is the minimum membership requirement for each Forum:

- Chair; this needs to be someone in a very senior managerial position within a board. He/she should be seen to be representative across the whole health board area and of sufficient seniority to be able to deliver against the 10 key recommendations of the HOPE report
- Social work representative (should be approved by the local authority Chief Social Work Officer)
- Consultant Psychiatrist
- Clinical psychologist
- Allied health Care professions representative
- Medical Manager
- Nurse manager
- Ward Charge Nurse
- Voluntary organisation representative
- Representatives from local service user groups
- Carer
- CHP representative
- Advocacy group representative
- CMHT representative
- An educationalist involved in nurse training

It is recognised that this is a large group but it was felt that this group had to contain senior people with the authority to make high level decisions where necessary and at the same time be representative of the large number of stakeholders in this area. Consideration could be given to having a decision making executive within each forum with a working group structure.

The Forum should meet a minimum of five times per year. It is strongly recommended that the Forum visit inpatient facilities that it covers at least once a year.

### **Funding**

The Health Board will be responsible for funding the local Acute Inpatient Forum and for providing a suitable venue.

### **Accountability**

The work of the Acute Inpatient Forum will be overseen at a number of levels. It is anticipated that a strategic group will be set up to continue the work of the Mental Health Delivery Group which will have responsibility for guiding the setting up and development of the Forums. At Health Board level the Forum will report to the Chief Executive who will also ultimately be responsible via the Annual Accountability Review which deals with HEAT targets (one of which pertains to acute in-patient care). The Chief Executive will be responsible for any high level actions arising from the work of the Forum.

The Forum should also be overseen by the local Performance Management (JLC) process.

Forum minutes and any reports they produce should be sent to the Board Chief Executive, the Local Authority Chief Executive, and to all partner agencies. The Mental Health Division of the Executive should also receive these. Information on the work of the Forum should be available on the locally appropriate websites.

### **Remit**

We have no wish to be overly prescriptive with regard to the remit of the Forums as we recognise that they will need to take account of local strengths and weaknesses in prioritising their work. The HOPE report contains more detail on the remit of the Acute Inpatient Forum and suggest 10 key areas on which should direct the work of the Forum. These are:

- Inpatient wards must exhibit a culture that inspires hope, trust, confidence and well-being for both patients and staff.
- All units need to be equipped to a high standard, be clean, adequately furnished and in a good state of repair.
- Patients must have access to a good range of therapeutic activities both in the ward, and be able (where appropriate) to access facilities in the local community.

- There must be appropriate and timely access to the range of skills, experience and expertise that exists within a well developed multidisciplinary/multi-agency service.
- Staff working within acute in-patient settings will receive the right training and supervision to respond effectively to the needs of people they work with.
- All units will have multidisciplinary/agency risk assessment and management structures in place.
- Minimum standards and monitoring mechanisms will be in place for those critical service/service user interfaces; admission/discharge procedures, multidisciplinary note keeping, data collection etc.
- Local services will demonstrate through practice and policy an integrated service that aligns both inpatient and community resources towards a common purpose and priority.
- All acute units will have in place policies on challenging/unacceptable behaviour that clearly sets out the working relationship between staff and service users; one built on trust and respect.

The initial priority of the Forums will be to significantly improve the patient's experience on the ward however the ward does not operate in isolation. We expect the Forum to be fully engaged in wider planning and operational issues concerning the local mental health framework and the integration and redesign of acute care provision. In the fullness of time the Forum should also consider other issues which were deemed to be beyond the remit of the HOPE group including single sex wards, the desirability of sector based services and the notion that "one size fits all" in terms of provision of care within inpatient units - ie is there a need for more specialist units for some clinical sub-groups.

Finally Acute Care Forums will be required to report to the executive by 2009 on what work they have done and what improvements have been achieved. Evidence around this should be validated by service users, carers and staff.



**Delivering for Health:  
Delivering for Mental Health: Establishing Acute Inpatient  
Forums and improving care  
December 2006**

*“We will establish acute inpatient forums across all Board areas comprising service providers service users and carers as well as other stakeholders such as local Authority colleagues”*

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## Introduction

This report supports and informs the Mental Health Delivery Plan and *Delivering for Mental Health*.

There is a strong focus on acute inpatient care, together with attention and action needed in the community and primary care, with service users and carers around early intervention, better management and treatment.

A new HEAT target has been set on acute inpatient care and there are a number of commitments which will collectively help to address this agenda. These are:

- To reduce the number of re-admissions (within one year) for those that have had a psychiatric hospital admission of over 7 days by 10% by end December 2009. (NHS HEAT Key Performance Target);
- To develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights (ROPI). This tool will be piloted in 2007 and be in general use by 2010;
- To have a training programme for Peer Support Workers in place by 2008, with Peer Support Workers being employed in three NHS Board areas by end December 2008;
- To increase the availability of evidence based psychological therapies for all age groups in a range of settings and through a range of providers;
- NHS QIS to develop standards for 5 condition specific ICP's by mid 2007. They will also develop the accreditation process/stages to be rolled out during 2008;
- To have key front line accident and emergency staff, along with key staff in the community/primary care educated and trained in using suicide and self harm assessment/diagnostic tools. 50% of those staff identified to be trained by end December 2010;
- To offer more effective management and care for people in the community and avoid inappropriate admissions by ensuring the published (2006) Crisis Standards and services are in place by end December 2009;
- To reduce admissions of children and young people to adult beds by 50% by 2009 (against a baseline figure for 2005/06 of 69 admissions); and
- To implement the Care Programme Approach for all restricted patients by end December 2008.

**There is also a commitment to establish Acute Inpatient Forums (AIFs) in every NHS Board area by end December 2009. This commitment is addressed in this report.**

As well as the targets and commitments, support for delivering change will also be provided in the shape of:

- An Improvement programme;
- A Leadership Programme;
- Commissioned work by NES on training in talking and psychological therapies;
- Benchmarking and information use; and
- Knowledge Exchange.

These support structures will assist NHS Boards and partners to deliver the *Delivering for Mental Health* targets and commitments including the establishment and running of the Acute Inpatient Forums across the country.

Concerns have been expressed in the past about the state of acute inpatient care and while standards in some areas are excellent, the variation elsewhere needs to be addressed.

The appropriate emphasis on community based mental health services can have unintended consequences for patients who continue to require inpatient care.

A number of organisations and individuals have identified concerns. The 2004 Review of Mental Health Services in Scotland included a section written by service users which supported the view that energy and commitment to change was needed by all if hospital care was to be a more positive experience with positive outcomes. These comments are broadly supported elsewhere but experience has shown insufficient national progress toward change and improvement.

The issues include the physical environment (overcrowding, noise management and access to the outdoors), wider environmental issues (safety, privacy and dignity), work pressures and poor relationships with service users/carers (lack of communication and information).

Early in 2006 representatives of the Royal College of Psychiatrists (Scottish Division) and the Scottish Association of Mental Health (SAMH) discussed these concerns and raised the issues with the Scottish Executive Health Department Mental Health Division.

SAMH and the Royal College of Psychiatrists were invited by the Mental Health Division to bring together a group to examine the issues and make recommendations for change and improvement within the acute inpatient sector in psychiatry. A representative Short Life Working Group was established in Spring 2006 (Appendix 1).

The Group set 4 work streams:

- Service user feedback;
- Ward culture and values;
- System related issues; and
- Examples of good practice (see appendix 2).

Progress with each produced the following considerations:

- What should good acute inpatient services look like and how to achieve this?
- What current levers for change exist to produce improvements?
- What single recommendation could improve acute inpatient services?
- What outcome measures could apply?

At the initial meeting members of the group raised concerns about wider aspects of care. These included addressing issues such as: single sex wards; individualised vs. “one size fits all” care; sectorised care delivery; the role of inpatient care, and the values underpinning inpatient care. It was agreed that whilst these should remain on the agenda, the focus of the report should be on the initial four aspects identified by the SEHD.

The remit of the Group extended to intensive psychiatric care units (IPCU), but not to care of the elderly wards although it is recognised that many of the issues raised will have equal application in that sector.

## What good acute inpatient care should look like and how to achieve this

The Sainsbury Centre Report 2006 and also the HUG reports of 2001 and 2003 offered context, background and proposals to draw from. Several aspects of good acute inpatient care are highlighted in particular, including:

- a. **Ward culture** – A range of elements apply; in particular, what a ward “feels like” is as important as what it looks like. (Both are relevant).

The culture of a ward is set by the people who work there and the values to which they aspire. “Good ward culture” is shorthand for positive and supportive relationships between staff, service users, relatives and carers.

A clear vision shared by all of how to help service users towards recovery is essential.

Of significant importance is that service users are, and feel, valued. Service users should be encouraged to participate as fully as they can in their care and treatment. Staff and service users being treated with respect sets a positive tone of being valued.

Important aspects of ward culture will capture:

- User centred service;
- Focus on recovery;
- Focus on social inclusion;
- Equality, diversity, cultural and spiritual awareness; and
- Promotion of the principles of the Mental Health(Care and Treatment) (Scotland) Act (2003) including sections 25 and 26.

- b. **Physical environment** – A ward should look welcoming and homely but not be a home. It should provide sanctuary and safety.

Important aspects of the physical environment will capture:

- Cleanliness and hygiene;
- A single sex environment;
- Maximum space standards with access to quiet areas;
- Healthy food and access to drinking water;
- Facilities for sleep;
- Toilet/Shower/bath room facilities;
- Access to exercise facilities (both in and outwith the hospital where feasible);
- Well maintained furnishing and décor; and
- Rooms for consultations and private meetings.

### **c. Activities within the ward**

It is important that a range of activities are available to all patients, outwith normal working hours and at weekends. Different therapeutic activities should be considered (physical, fun, artistic and creative). To encourage participation, service users should be involved in discussions about the kind of activities they would like to see in a ward.

### **d. Information**

Service users and carers should have access to good quality, understandable information in a number of areas including:

- Participation in the development of their care plan;
- Who their consultant is, accessibility to care plan and role of key worker;
- Their illness and treatments, medication and psychological treatments;
- The admission and discharge process including ward activities; and
- Other (non NHS) services of relevance to them e.g. advocacy, housing benefits etc.

### **e. Access to staff (including access to psychological therapies)**

Access to staff by patients is of singular importance in any care environment and in any positive relationship between staff and patient. Patients need regular access to key workers and to know they are being listened to.

Delivering this important aspect will capture and include consideration of:

- *Administrative support* to relieve nursing staff of certain administration tasks. (The value of this is already proven through posts established in medical, surgical and obstetric wards);
- *Use of trained volunteers* to befriend patients, (this is complementary to existing staff and does not replace therapeutic contact);
- *Complementary therapies*;
- *Access to multi-disciplinary staff* including paid peer support workers; pharmacists, dieticians, voluntary sector staff, physiotherapists and psychologists (in addition to doctors and nurses); and
- *Links with implementation of the Mental Health Nursing Review* in relation to acute care.

Engaging more clinical psychologists and occupational therapists to work in an inpatient setting is an important consideration. However psychological therapies can be (and already are) delivered by staff other than clinical psychologists.

There are now a large number of nurses and psychiatrists who are trained in psychological interventions. Consideration should be made of how best to use this valued skilled resource to better effect, perhaps through protected time. There are links to be made to the work being taken forward by NHS Education Scotland in relation to training in talking and psychological therapies.

## **f. Training Issues**

All staff should have access to ongoing appropriate training. Both the National Review of Mental Health Nursing in Scotland and other key documents highlight the importance of ongoing appropriate training for staff. Monitoring mechanisms for uptake should be in place.

## **g. Risk management and safety**

Good risk assessment and risk management procedures need to be in place. A balance must be struck between the reduction of risk and the provision of a therapeutic inpatient environment, and in line with the principles of the new Mental Health Act with the least restriction being placed on service users. No ward or service can be entirely risk free and the involvement of service users and carers is essential in developing a service that strikes the right balance.

Good risk assessment practices help staff and service users alike. Individual care plans provide a basis for the appropriate management of risk.

The physical environment, operational processes and available resources of any inpatient service should be appropriate for the provision of the assessed care of individual service users, including the management of risk.

There should be a clear local understanding of the degree of risk that can be safely managed in any particular acute inpatient service. Again the link should be made to the work NHS QIS are taking forward around admission and discharge.

## **h. Process issues**

A number of process issues are of importance in the provision of good care. These include:

- Systematic collection and analysis of clinically relevant data;
- Good, collaborative and accessible multi-disciplinary case records;
- Clear policies on referral, admission and discharge;
- Good discharge planning, commencing immediately on admission; and
- The need for protocols on how and when clinical information on service users should be shared between staff.

**i. Provision of integrated services**

Excellent and effective acute care is best provided within a locally integrated mental health service. Services which operate as silos can lead to the detriment of service user/carer experience and outcomes.

Solutions to the challenges faced by acute services rest in whole system approaches. This can involve significant change in the organisation of acute care including, where needed, a realignment of community services towards a common purpose, that matches services to fit people's needs (*Bowles, N, 2005*).

Best practice suggests the ongoing involvement of community services on and following admission. Again there are links to be made with the NHS QIS work around standards for admission and discharge.

**j. Policies on challenging issues**

Care in safety is a clear objective for all. All services should have protocols under regular review which accord with the guidelines set out in NHS HDL (2002) 41 on Managing Incidental Drug Misuse and Alcohol Problems in Care Settings. Protocols should also be in place on measures to prevent sexually inappropriate behaviour, ensure respect for cultural diversity etc, as set out previously.

## How can we make this happen?

A number of approaches can be adopted to aid delivery, including:

### a. **Staff support and training**

A high priority should be given to ongoing training for inpatient staff within a learning and improvement culture. Staff should be encouraged to carry out self-audit and evaluation and have annual appraisals. Staff should have a Personal Development Plan identifying training needs. Protected time should be considered to allow time for training, clinical supervision and contact with patients.

### b. **Clinical Leadership**

Strong clinical leadership from doctors and nurses is an important aspect. Consultant Psychiatrists and senior nurses with managerial responsibility for inpatient care need influence and authority to drive change. Links will need to be made to the planned Leadership programme, part of *Delivering for Mental Health* initiative.

### c. **Investment in the environment**

We believe a national minimum standard for inpatient environments should apply to all units to raise the standards of all units towards those of the best. The Royal College of Psychiatrists Research Unit is currently considering a ward accreditation scheme. Links should be made to this consideration in advancing change.

### d. **Accountability**

NHS Boards are accountable for standards of acute inpatient care. Delivery of acute inpatient care also requires input from agencies other than health - particularly social work, but also housing and education.

Local accountability mechanisms are needed including those at Community Health Partnership level to identify lines of accountability from staff in all relevant agencies to the identified NHS Board senior manager. This should not be delegated beyond those with the authority or resources to make the necessary changes in the whole system.

### e. **Integration**

Acute inpatient services and units should be seen as part of the spectrum of care and not as separate entities from community care. They are an integral and essential element in the local service framework. Their role is to help people recover and move on in their lives. To achieve this, acute units need to reach out to the community and invite the community resources to reach in.

### f. **Skills**

At a time when service users can be vulnerable the best care is needed to support them. Working in acute care settings is a specialised role requiring high levels of skill and experience.

**g. Best Practice**

Consideration should be given to all arrangements for the sharing of best practice (see Appendix 2) including the merits of an acute care best practice network.

**h. Delivering for Mental Health**

In Scotland, the commitments in *Delivering for Mental Health* should help to address these issues which in turn will be part of the NHS Board Chief Executives' agenda.

## Levers and opportunities for change in the current environment

We believe the current climate around change and the need to measure performance provides an opportunity for changing and improving acute inpatient services. The following apply:

**a. The Mental Health (Care and Treatment) (Scotland) Act 2003**

The principles of the Act will underpin delivery of change and improvement in all mental health services.

**b. The National Review of Mental Health Nursing in Scotland**

This review is particularly supportive of recovery based approaches. The action plan chimes with the aims of this report including programmes for the education, training and continual professional development for acute inpatient care, staff developing inpatient models of care based on the principles of the Act and on the recovery approach (points 5 and 6 respectively).

**c. New ways of working for psychiatrists**

The NIMHE (National Institute for Mental Health)/Royal College of Psychiatrists pilots arising from this document highlight the benefits of cultural change and a whole systems approach.

**d. Accountability**

Accountability needs to be both local within health and social work services and also at NHS Board level.

**e. Delivering for Health**

The new policy for NHS Scotland, *Delivering for Health* (2005) sets out a new vision for delivering services based on a fundamental shift in the way the NHS works. This includes:

- a move from an acute, hospital-driven service to one that is community based;
- a focus on meeting the twin challenges of an ageing population and the rising incidence of long term conditions;
- a concentration on preventing ill-health;
- a focus on treating people faster and closer to home; and
- a determination to develop responses that are proactive, modern, safe and embedded in communities.

**f. Delivering for Mental Health**

Proposes the development nationally of standards for Integrated Care Pathways for five conditions: depression; bipolar affective disorder; dementia; personality disorder and schizophrenia. Pivotal will be the processes for admission, care planning and discharge. The development and implementation of ICPs has the potential to make a positive impact on the standard of care for inpatients.

**g. Service user experience**

Meaningful, early and continuing service user and carer involvement needs to be reflected in delivery and change.

## **Recommendation for inclusion in *Delivering for Mental Health***

We believe that changes in acute inpatient care can be maximised by the creation of Acute Inpatient Forums. An inpatient profile should be developed for each NHS CHP/Board area which has acute psychiatric beds. A profile for each CHP/ NHS Board might reasonably be expected to include the allocation of resources, use and practice in each ward including:

- Demographic and clinical information on inpatient service users;
- Availability and use of community treatment;
- Application of the Mental Health Act;
- Data on admissions, re-admissions and length of stay;
- Availability, allocation and supervision of staff;
- Service user/carer involvement;
- Consultant involvement;
- Aspects of the ward environment and activities within the ward;
- Communication and coordination of services across agencies;
- Staff training; and
- Staff Activity.

It is crucial that an appropriate framework is put in place to deliver and report upon progress against objectives contained within the *Delivering for Mental Health*.

In keeping with the delegated authority and responsibility of the AIF each should undertake to identify a Chair and ensure that the Chief Executive of each NHS Board is aware of and involved in the mechanics of making the Forums work. Focus should include the following:

- Effective multi-agency commitment to the delivery of the overarching objectives;
- A local action plan reflecting strengths, gaps, needs and priorities within the local service framework;
- Clear deliverable targets and measures to monitor and report on progress;
- Clear plan to maximise the input of people's experiences of living and those working on acute wards;
- Promote and enable cross boundary working;
- Collect and collate performance information and data;
- Ensure action plans and priorities are reflected in the local NHS, CHP and Local Authority planning structures; and
- Improve and address quality and performance issues.

Acute Inpatient Forums (AIFs) will be charged with the responsibility, authority and accountability to develop, deliver, evaluate and report upon local progress against the overarching issues raised in this report. AIFs will prioritise their actions to reflect local needs and circumstances recognising the variance in performance across the NHS Board areas. There should be an Acute Inpatient Forum for each NHS Board area.

Each NHS Board needs to agree the mechanism for frequency of meetings and how the minutes of meetings and other material will be communicated across services and at the same time to partner agencies. The financial cost of running and servicing meetings and agreed actions will be met from NHS Board resources.

The mechanism for feeding back on the activity of the Forums will be through an enhanced performance management structure. AIF action will be monitored through an enhanced performance management system to be in place by March 2007 and there will be an opportunity for dialogue with SEHD colleagues through a rolling visiting programme. These arrangements will build on existing visiting, monitoring and other processes and will be designed to engender a positive experience for all concerned in advancing the *Delivering for Mental Health* targets and commitments.

## **Leadership, membership and reporting systems**

Forums need to effect positive, sometimes immediate and crucially, sustainable change within the acute care setting. NHS Boards need to delegate the appropriate level of authority and responsibility to the Forums to achieve this objective.

Forums will be expected to demonstrate delivery. Leadership/Chairmanship of the Forum must be of sufficient seniority to make resource decisions.

Senior medical, nursing and social work staff together with mental health lead from Community Health Partnership, service users and carers, voluntary sector representation, health improvement, training, planning and information officer all need to be engaged in the Forum.

### **What outcome measures need to be in place?**

Service users need access to the right care and treatment, at the right time, in the right environment and delivered in a way that puts them at the centre of their care and not at the centre of a system.

To aid recovery, quickly and with the right supports service users should feel involved and in control of their own lives, and have high expectations of themselves and of the services they access.

Staff should feel and be valued, involved, respected and supported. Positive work environments and structures engender creativity and innovation. The best mental health systems are those backed with excellent resources, information, leadership and training. To create acute wards as centres of excellence will require full partnership with service users, carers, NHS staff, social work, housing voluntary sector and primary care colleagues.

It is essential that robust outcome measures are in place for the right changes at a pace that reflects the very real need for change. The recommendations contained in the SOSS report (April 2006), offer insights for the adoption and mainstream practice of using mental health outcome measures in routine clinical practice. Outcome measures need to be about both process and people. Process outcomes might include:

- Discharge planning against an agreed standard;
- Length of stay;
- Re-admission data;
- Use of the Mental Health Act;
- Data on frequency of inappropriate behaviours in wards e.g. instances of use of illicit drugs; and
- Assessment of interagency and whole system working.

Other outcome measures could include:

- The Recovery Orientated Practice Index ;
- Avon Mental Health Measure;
- Measures of service user and carer satisfaction;
- Camberwell Assessment of Need;
- Measures of staff satisfaction;
- Data on staff sickness and retention rates;
- Results of inspections of inpatient facilities against an agreed standard (see above);
- Delivery of actions arising from the National Mental Health Nursing Review;
- Ensuring that all staff have values based training;
- All registered practitioners to have skills based training in delivering psychological interventions and be able to demonstrate the delivery of these skills;
- Availability of information to service users and carers (again against an agreed standard);
- Training and Development of staff;
- Availability of support for carers; and
- Outcomes from Critical Incident Reviews.

Links will need to be made the work being taken forward under the Benchmarking initiative.

### **Conclusion**

Improving acute inpatient care is a challenging but necessary and urgent task. There are important roles for all staff, particularly for NHS Board Chief Executives in establishing and operating the proposed Acute Inpatient Forums and for delivering with partners on the commitments made and targets set in *Delivering for Mental Health*.

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## Appendix 1

### Membership

Ms Karen Addie	Policy Manager, Royal College of Psychiatrists, Scottish Division
Ms Pamela Black	Service User, Scottish Association for Mental Health (Irvine)
Ms Angela Boyle	Senior Administrator, Royal College of Psychiatrists, Scottish Division
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Ms Susanne Forrest	Programme Director, Mental Health, NES.
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Ms Alison Guest	Member, NSF Scotland Board and Primary Carer
Mr Nigel Henderson	Director, Penumbra
Mr Hugh Hill	Director of Services and Strategy, Scottish Association for Mental Health
Ms Ruth Lang	VOX Member and Information Officer, Depression Alliance Scotland
Dr John Loudon	NHS Quality Improvement Scotland
Mr Jamie Malcolm	Nurse Commissioner, Mental Welfare Commission
Ms Sharon McMenemy	Charge Nurse, Acute admissions, St John's Hospital, Livingston
Mr Shaun McNeil	Interim Secretary, VOX (Voices of Experience)
Dr Debbie Mountain	Consultant Psychiatrist, Rehabilitation, Royal Edinburgh Hospital
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Dr Premal Shah	Consultant Psychiatrist, Royal Edinburgh Hospital
Ms Gilly Waite	Charge Nurse, Huntlyburn House, Borders
Ms Mary Weir	Chief Executive, NSF Scotland

### Good practice examples

#### Collated examples of food practice relating to accommodation and activities

##### **Mental Health Nursing Review**

In NHS Borders there has been investment in activity coordinators to ensure service users have access to a structured programme of therapeutic activities and also a project that has enabled people to access complementary therapies.

##### **Mackinnon House, Stobhill**

Award winning occupational therapy department, Lifeskills.

##### **Meadowfield Acute Admission Mental Health Unit, Worthing**

The unit is a new build, consisting of three, 16 bedded mixed sex wards. Meadowfield is situated in a residential area, some miles away from the town centre.

The unit is bright and airy with lots of natural light and designer lighting. The walls are pale with accent colours via furniture and soft furnishings and are very clean. Each ward is on the ground floor with access to garden areas, which are not overlooked by wards. All of the bedrooms are single with matching furniture and en-suite facilities with built in safety features. There are small living spaces and quiet areas. There is a galley kitchen for service users to make drinks and snacks. The garden is being landscaped with input from service users.

There is also a ward based activity programme which has a good uptake.

##### **Acute Care Collaborative, run by the King's Fund and Care Services Improvement Partnership's London Development Centre**

This programme involved 34 inpatient wards in 30 London boroughs over 15 months. Wards could choose some of 25 standards to work towards. One of the most popular was for all service users to be involved in negotiating an activity and therapy programme that includes evening and weekend activity (such as a morning group where service users cooked their own breakfast). This standard increased service user participation in activities from 13% to 40%. More activities enhanced the effectiveness of inpatient admissions.

## **National Patient Safety Agency Safer Acute Wards Project**

Project reviewed available evidence:

Lawson & Phiri (2003) recommended a top-up culture that ensured organisational systems work to the benefit of the ward – so e.g. repairs, cleaning etc can be controlled by staff in the ward, to improve morale and sense of hope.

Project went on to pilot improvements in three areas, one of which was improving the Physical Environment through Local Management. Information on these pilots has been requested.

### **Newcraigs Hospital (extract from MWC unannounced inspections report 2005)**

24 en-suite rooms and ample communal space. The ward is light, spacious, and attractive and appeared well maintained, and, apart from some problems with controlling cigarette smoke, was a very pleasant environment to be in.

Also – two of the wards visited had a “slow door” operating system that delays the opening of the door for a few seconds. This can remove the need to lock the door, and was popular with the patients and staff.

### **Department of Health Mental Health Policy Implementation Guide Adult Acute Inpatient Care Provision**

**Oakburn ward:** “Nurses actively engage with service users in one to one sessions and groups. The environment is carefully managed to minimise noise and promote a sense of calmness and safety. The ward is highly structured, yet some of the changes made have been focused on reducing controlling interventions and replacing them with caring interventions. Nurses are more proactively engaged and spend less time “fire fighting”. Strong leadership and improved teamwork have supported clinical changes. The service’s own audit data shows that patients are more engaged with their named nurses, 95% of patients take part in structured one to one time daily, and consequently are better informed and more involved in their care.”

**Eileen Skillen ward, Brixton.** “Service users are offered a range of activities to support their recovery with a range of diverse activities available. A patient community meeting is held once a week to help discuss and resolve people’s concerns and as many decisions as possible are made democratically, from changes in the physical environment to asking ex-patients to participate actively in staff interviews.”

**Collingwood Court in Newcastle** “benefits from the advantages of having created an ideal environment to meet the privacy and dignity needs of service users with a general mixed-sex area, a female-only environment and an area for patients requiring high levels of nursing observation. Service users and carers play an integral role in their own care and the ongoing development of the ward. Structured, varied therapy is available and given the much-improved physical environment of the ward, participation in activities is high from service users. The ward has been independently hailed as an area of good practice by Breakthrough.”

### **Suggestions received on what creates good practice:**

- Good, sound leadership
- Staff who have all the training and skills to do the job
- A value-based ward philosophy
- Sound appraisal and PDP framework for all staff
- Regular supervision for ALL staff
- A pleasant and safe environment
- Regular planning groups between staff and patients to plan activities and ensure a venue to air views
- Sound, robust and meaningful activities on offer to all patients including complimentary therapies
- Sharing of information to service users and carers, both verbal and written re.
  - Diagnosis
  - Treatments
  - Assessment Process
  - Services available – both ward based and locally
  - Observation charts
- A culture of engagement with service users and carers
- A culture where staff can feel free to air views – be innovative and think out of the box
- Management structure and medical counterparts who fully support and embrace all of the above
- Having sound systems and policies in place i.e. Risk Management/Observation/H&S, etc.

### **REHAB Ward, Royal Edinburgh**

Recreation nurses who take patients off the ward for all sorts of activities, both singly and in groups. Getting a commitment to an in-patient OT presence is essential to maintain a therapeutic as opposed to custodial regimen. The ward atmosphere has benefited from the refurbishment and increase in floor space that was part of the Safety Dignity and Privacy drive - which happily came with a budget.

More recently our ward staff complement has been expanded hopefully to reduce stress levels and reduce use of bank nurses but also to permit a rotation of nurses between day and night shift to keep that time therapeutic too. Our ward is thinking about introducing dedicated therapeutic time to improve key working. This would mean a block of the day when student/visitors/interruptions in general would be discouraged.

Finally, the availability of advocacy services has been a great benefit. Our ward worker is a gem who sticks to the model firmly yet encourages the patients to be as active as possible in shaping their own recovery.

## **Good practice relating to areas other than accommodation and activities**

**Royal Cornhill Hospital in Aberdeen.** One of the psychotherapists offers a service to the acute unit providing urgent assessment of patients with personality disorders. She then works with staff and the patient advising on ongoing management. In addition she provides a weekly meeting for nursing staff where they can discuss so called "difficult patients". Staff and patients have valued this service.

## **Examples submitted to Mental Health Nursing Review**

Person-centred care in practice – implementing the Tidal Model in inpatient care in NHS Greater Glasgow.

The Tidal model builds upon the nursing profession's core concepts of caring about people and is based on collaborative working that promotes people's strengths and attributes to bring about change in their own lives. The values of the model link well to the Mental Health (Care and Treatment) Act 2003. Focused individual and group work promotes recovery-centred working.

NHS Greater Glasgow has implemented the Tidal Model in several inpatient units across the city. Encouraging results have been found, including reduction in rates of physical and verbal aggression, self-harm, complaints and the use of restraint and observation. Additionally, nursing staff have consistently reported a greater sense of professional purpose and job satisfaction after the introduction of the model, and service users and carers are very positive about the recovery-focused approach and the opportunities the model presents for meaningful involvement in their care.

## **Putting recovery into practice – NHS Tayside**

With the support of SRN, a group of mental health nurses, carers, social workers, service users and occupational therapists have taken "training for trainers" courses in recovery. The Tayside Recovery Network has now been set up to support cultural change to embrace recovery-focused practice. The network has devised a vision and strategy for supporting the dissemination of recovery into practice which includes:

- Recovery awareness-raising sessions
- Training others as recovery trainers
- An email network and intranet forum
- The development of recovery training packages

Early indications are that the principles of recovery are taking root in Tayside. The network is increasingly being asked to comment on new procedures and policies to ensure they are consistent with the principles of recovery. There is a strong belief among nurses in the network that recovery principles are the vehicle to support cultural change and to allow mental health nurses to reclaim and strengthen their art.

There is a pressing need to improve access to psychosocial therapies for people during their stay in acute inpatient units. A nurse-led initiative in NHS

Argyll and Clyde enables people to access psychological assessment and therapies during their admission, helping them to increase understanding of their problems and explore psychological treatment options that will support their ongoing coping and recovery. Nurse therapists also provide training, supervision, and support to the wider nursing team to promote psychological thinking and embed psychological therapies into practice.

In NHS Highland, a transitional discharge pilot has been completed in collaboration with Stirling University, with encouraging results. The transitional discharge model is well established in parts of Canada and involves the nurse who cares for an individual during an inpatient stay maintaining involvement during the transitional period after discharge while the person establishes a relationship with community staff. The Highland pilot also included peer support for people post discharge. The outcome of the pilot produced evidence that transitional care was effective in reducing readmission rates.

### **Mackinnon house, Stobhill**

Successful pilot of the TIDAL project on Struan, which is a nurse based form of psychological therapy.

Armdale has piloted the integrated care pathway for schizophrenia over the last year.

### **Glasgow Perinatal Mental Health Service**

Established a staffing rota so inpatient staff nurses rotate into the community and take on community cases under the supervision of CPNs. Two E-Grade nurses are in the community at any one time. The aim has been to break down traditional barriers between in and outpatient services, enabling staff to see themselves as one service, to provide seamless follow-up for discharged inpatients, who can often be seen in the community by their inpatient key worker, and to motivate inpatient staff to develop autonomy, skills and therapeutic interventions which can enhance their care of inpatients. The feedback from staff has been very positive and the service won a nursing award for the innovative practice.

### **Acute Care Collaborative, run by the King's Fund and Care Services Improvement Partnership's London Development Centre**

This programme involved 34 inpatient wards in 30 London boroughs over 15 months. Wards could choose some of 25 standards to work towards. Some of the most popular were:

- Naming a staff lead on dual diagnosis, who will have completed a five-day training course
- For all service users to meet with their primary or named nurse within seven days
- For all service users to have twice-weekly, documented sessions with their primary or named nurse
- For specialist substance misuse/dual diagnosis workers to provide in-reach services to an inpatient ward

There was an increase in success from 17 to 60% on the first standard, from 26 to 55% on the second and from 23 to 67% on the third. In-reach work by substance misuse workers saw the biggest rise, from 13% to 73%. Protected time – when the wards shut down to phone calls, paperwork, professionals and visitors – targeted dual diagnosis, and training were the most popular pieces of work. Three of the trusts are extending protected time to all wards because it leads to a calmer atmosphere and reduction in incidents. Staff say the dual diagnosis training was particularly useful in changing attitudes towards service users with a substance misuse problem.

### **Department of Health Mental Health Policy Implementation Guide Adult Acute Inpatient Care Provision**

Good practice aspects of reception and service orientation include:

- a service user handbook/guide on what is available and how to access it
- clear policy on leave, access, contact with relatives and friends, visiting times, access to telephones
- code of conduct – including what to expect from staff and what is expected of all users on the ward
- explanatory information (written, video) on illness, symptoms, services, courses of treatment
- a picture board of ward staff, prominently displayed
- a floor plan/map of the ward and the unit and good signage
- a service user orientation checklist as part of care plan
- a clear reception/orientation policy

### **Eileen Skillen ward, Brixton**

To help encourage staff recruitment and retention, the ward provides flexible working arrangements. Staff are proactive about their own learning and development. On the ward, there are two teams working to two consultants and every three months, each team will have a workshop. The second team will cover for the first team to allow them to meet, brainstorm challenges and map out solutions. The approach allows staff to engage in reflective practice with minimal disruption for patients.”

“A number of innovative services have beneficially created service user support posts to enhance sensitivity to service user concerns and to assist in creating additional therapeutic capacity for staff engagement.”

“**Anam Cara Crisis House, Birmingham** was set up in 1997, in conjunction with the local home treatment service, to provide an alternative to hospital admission for women and men (in practice working primarily with women) and a “sister” designated women-only crisis house, Celine, opened in 2001. Both houses work on a hope and recovery model with a special focus on a diverse range of complementary therapies. The ethos is very resident-led with staff regarded as “recovery guides” all of whom have had prior experience of mental distress.”

**“Pathways**, based at Goodmayes Hospital within North East London Mental Health NHS Trust, has put in place a comprehensive practice development programme with four key components:

- service user empowerment – moving from paternalism to partnership
- multi-disciplinary working and training
- clinical and managerial systems
- research, audit and evaluation

With a team of staff from different disciplines, the unit provides therapeutic, safe care and treatments for people who cannot be safely managed on an open acute ward.”

**“Bolton Acute Practice Development.** The “Refocusing in Bolton” project was initiated in September 2001. Two parallel groups lead on refocusing – an acute development forum which meets quarterly, made up of multidisciplinary staff, representatives of the Patients’ Council, PCT and an advisor from the University of Bradford. The second group focuses on leadership, is composed of all acute F and G grades and the OT manager, meets more frequently and agrees changes for all four wards, ensuring consistency and providing a valuable opportunity for mutual support and peer learning. We have undertaken whole team training and have made sure that everyone can attend. Our values and practice changes are being phased in, the first implemented in January 2002, which has been widely supported by staff and patients.”

**“Northern Collaborative.** The Mental Health Collaborative was set up in October 2000, jointly commissioned by Trent and Northern and Yorkshire NHS regional offices and the Northern Centre for Mental Health. The overall aim of the project has been to improve inpatient care by focusing on enhancing service users’ experiences of admission, stay and discharge. The project brings together the experiences and ideas of 37 acute care teams in the Northern region of England, assessing their current comparative position and setting incremental service improvement targets.”

### **SAMH (2004) Hospital admissions best practice**

Good practice points:

- being told who your named nurse is on admission
- Being able to contact the ward for support/advice/prescription of e.g. sleeping tablets when experiencing “warning signs”
- Provision of crisis facilities – midpoint between community and hospital
- Culture in which views of service users and carers are given weight
- Staff and service users working together when they are well to plan how to handle things if they become unwell – advance statement
- A&E departments should have a “liaison nurse” trained in mental health
- Welcome/induction pack for patients when first admitted
- Freephone helpline in wards to advocacy or support organisation

## **Scottish Executive (2002) Don't they call it seamless care? A study of acute psychiatric discharge**

Identifies good practice in components of a discharge strategy

- identification at the admission stage of elements from the wider social context, for example accommodation or finance, which need to be addressed prior to discharge
- clear identification of lead responsibility in relation to the discharge planning for each individual
- agreement and implementation of protocols for the communication of information between hospital and community and between a range of different professionals. This should include details for the notification of GPs, consideration of the timing of the initial out-patient appointment, and communication of procedures to be followed for crisis contact
- Involvement both of individual service users and, where relevant, their informal carers in the detail of decision-making, ensuring the provision of information necessary for this process
- Clarification between psychiatrist and service user of the individual's diagnosis and its implications
- Provision for each individual of the details of medication and prescription arrangements, highlighting specific implications as appropriate
- Comprehensive assessment of need and maximisation of the extent to which areas of unmet need are addressed
- Specification of the routines for clarification of individual responsibilities within the multi-disciplinary work context
- Clarification of any tie-in to existing care management or CPA procedures
- Understanding of whether an individual can expect ongoing contact from professionals and the timing and arrangements for any review

**Key Recommendations to be taken forward by the Acute Inpatient Forums**

1. Inpatient wards to exhibit a culture that inspires hope, trust, confidence and wellbeing.
2. All units to be equipped to a high standard, be clean, adequately furnished and in good state of repair.
3. Patients must have access to a range of therapeutic activities both in the ward and be able to access facilities in the local community.
4. Good quality information to be available to service users and carers.
5. Appropriate and timely access to the range of skills, experience and expertise that exists within a well developed multidisciplinary/ multi-agency service.
6. Staff working within acute settings to have access to the right training and supervision to respond effectively to the needs of the people they work with.
7. All acute units will have multidisciplinary/agency risk assessment and management procedures in place.
8. Minimum standards and monitoring mechanisms to be in place for critical service/service user interfaces; admission/discharge procedures, multidisciplinary note keeping, data collection etc.
9. Local services to demonstrate through practice and policy an integrated service that aligns both inpatient and community resources towards a common purpose and priority.
10. All acute units to have policies on challenging/unacceptable behaviour that clearly sets out the working relationship between staff and service users- built on mutual trust and respect.

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