Mental Health STRATEGIES

THOUGHT PIECE

Untangling the knotty problem of acute care in mental health

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1. CONTEXT

Over the past year we have been spending a lot of time on an aspect of mental health services, which many hoped had long since been dealt with: **Acute bed pressures**. Recent years have seen a great deal of time and attention spent on things other than this aspect: on IAPT, on wellbeing, on dementia, on secure care, on specialist services. All of these are important topics, but, in the meantime, the difficulties building up in **acute care** have only relatively recently commanded the attention they surely deserve.

This paper therefore reflects on:

- The national picture in acute mental health care
- The common themes which are emerging from our work with local services
- Action which we think local providers and commissioners should consider taking

2. THE NATIONAL PICTURE: FAILING SUPPLY RISING DEMAND

There is range of evidence that mental health acute services are facing serious problems with provision of adequate, safe care. According to a survey conducted by BBC News and Community Care magazine, which sent a FOI request to 53 out of 58 mental health trusts in England, and received 46 responses, over 1,700 mental health beds were closed between April 2011 and August 2013, including 277 between April and August 2013. **This represents a 9% reduction in the total number of mental health beds available since 2011/12**.

This would of course be entirely proper if demand, and patient flow, were matching the reduction in supply. However, this does not appear to be the case. Data obtained by Community Care, under the Freedom of Information Act, from 30 of England's 58 NHS mental health trusts revealed that the number of patients sent to out-of-area hospitals rose 33% last year and has more than doubled since April 2011 from 1,301 people in 2011-12 to 3,024 in 2013-14.

According to the most recent data from the health and social care information centre, there were 48,631 detentions in 2011-12 under the Mental Health Act, an increase of 6.4% on the 2003-04 level. Care Quality Commission figures show 17,503 people were in mental health hospitals on 31 March 2013, up by 5% on the same date a year before. **The evidence therefore points to rising demand.**

Local stories confirm the potential impact of this situation. According to NHS England Bed Availability and Occupancy Data, there were no psychiatric beds at all available across London on at least two occasions during August 2013. In East Anglia, as reported by the Independent (2014), the situation has reportedly become so serious that staff, who regularly work excessive hours because they cannot leave their patients until a bed is found, are considering industrial action. In one incident, a mental health professional spent 22 hours with a patient who was eventually driven to a ward in Cheshire. Barnet, Enfield and Haringey has been reprimanded by the Care Quality Commission (CQC), for using seclusion units as bedrooms.

The effects of the shortage can also be seen in a recent Survey by Royal College of Psychiatrists (2014), involving 528 trainee psychiatrists working in mental health services across the UK. Some of the key findings were:

- 80% of respondents had sent a patient outside the local area for a bed, 15% doing this more than monthly;
- 37% had sent a patient at least 100 miles outside their local area. Of those working in CAMHS, 22% had been forced to send a child 200 miles away from their families;
- 37% said a colleague's decision to detain a patient under the Mental Health Act had been influenced by the fact that doing so might make the provision of a bed more likely, and 18% said their own decisions had been influenced in such a way;
- 24% of respondents reported that a bed manager had told them that unless their patient had been sectioned they would not get a bed;

- 20% have admitted a patient to a bed belonging to a patient who has been sent home on a period of trial leave;
- Three out of ten respondents had seen a patient admitted to a ward without a bed – presumably leaving them to stay on a sofa in a communal room;
- 28% have sent a critically unwell patient home because no bed could be found;
- although the Royal College of Psychiatrists *(Do the right thing: how to judge a good ward*, 2011) recommends occupancy levels of 85%, individual wards were running at up to 138%.

In response to the Royal College of Psychiatrist survey findings, care minister Norman Lamb said:

> ***"Decisions about detention must always be taken in the best interests of patients at risk of harming themselves or others. Inpatient beds must always be available for those who need them. We are scrutinising local NHS plans to make sure they put mental health on a par a par with physical health."(Quoted in BBC, 2014).***

3. FINANCIAL IMPLICATIONS

The financial impact of the acute mental health bed shortage has been significant; for example, the lack of secure inpatient beds has caused a 5% overspend in NHS England's budget for independent sector mental health providers (HSJ, 2014), totaling £21 million. At a local level, and for example, Manchester Health and Social Care Trust spent £1.7m in the first four months of 2013-14 sending 86 patients to a range of private providers, some as far away as Harrow in London. Barnet, Enfield and Haringey saw the cost of moving discharged patients into B&Bs increased from £46,000 in 2012-13 to £264,000 in the 10 months to January 2014.

4. THE CRISIS CARE CONCORDAT

Acute care matters: it is provided when people are most acutely ill. The Joint Commissioning Panel for Mental Health (2013) confirmed long-standing guidance that an admission should be considered where it would play a necessary part in a person's progress to recovery from the acute stage of their illness. Admission criteria need to include:

- the needs of the patient and family;
- risks posed to the individual and others;
- local availability of alternative interventions;
- goal and purpose of admission.

Additionally, the acute care pathway should have clear admission and discharge criteria in order to clarify the purpose of the intensive input that the acute care pathway provides, as clarity is helpful both to staff and more importantly to patients and carers.

From the above it is clear that these standards are now commonly not being met. In response to this situation, the government has issued the Mental Health Crisis Care Concordat, a document aiming to improve the standards of care provided to people who experience mental health crisis. The concordat, which has been signed by 22 organisations including NHS England, the Association of Chief Police Officers and the Royal College of Psychiatrists, describes how the signatories plan to together address the issues currently experienced by the NHS related to crisis care.

It sets out a number of principles; some of them are aimed directly at improving the situation of acute mental health beds. The document states:

- *'People in mental distress should be kept safe. They should be able to find the support they need – whatever the circumstances in which they first need help, and from whoever they turn to first. As part of this, local mental health services need to be available 24 hours a day, 7 days a week.'*
- *'Responses to people in crisis should be the most community-based, closest to home, least restrictive option available, and should be the most appropriate to the particular needs of the individual.'*

The NHS Mandate for 2014-15 contains an objective for the NHS to make sure that every community develops plans, based on the principles set out in the Concordat. So, how are things looking at a local level?

5. COMMON THEMES FROM LOCAL WORK

We are regularly seeing the realities of local pressures on acute services. Our work at a local level has enabled us to gain a detailed understanding of the way acute care services are functioning. There are of course differences from place to place. Four things, however, are almost constant themes in our work.

- Financial prioritisation
- The cost and consequences of overspill
- The importance of admission avoidance, and the role of CRHT
- Supported accommodation

i) Financial prioritisation

Acute services have been seen as a source of potential savings for many years. We are of course conscious that resources are limited, and that there is considerable pressure to make financial savings at present. It may well be inevitable that some current services cannot be sustained, or cannot be sustained at their current size and configuration. We would suggest, however, **that both providers and commissioners should commit to the needs of the most acutely ill being regarded as a very high priority, probably the highest priority, in any financial review process**. We are increasingly hearing questions as to whether local financial priorities need to change; if something has to "fall off the end" of affordability, perhaps this should not be acute care, of people who are the most ill. This is now an increasingly important debate in local services.

ii) The cost and consequences of overspill

Overspill – admitting people who are acutely ill to wards/services outside their usual providers' - is a problem with many consequences. We hear regular mention of problems such as:

- People are placed with staff who do not know them, with the risk of delays in the most appropriate care and treatment beginning
- Friends and relatives may find it more difficult to visit
- Links with local services will be weaker, potentially increasing the length of stay
- Time of many staff is taken up by managing and communicating about a remote placement
- Difficult choices may have to be made about "holding on" with an acutely ill person for a locally available bed – especially difficult where the person has been assessed as required admission under the Mental Health Act, and
- Money is taken out of the local system to pay for remote services

There is therefore a risk of a "vicious circle" developing, as these consequences increase future use of services by the patient placed into overspill, and decrease the local resources available to prevent future overspill. There is, however, the potential for a "virtuous circle", where any measures which enable overspill to be reduced will reduce the need for it in future. Overspill is a hugely significant issue for services experiencing it regularly.

iii) The importance of admissions avoidance, and the role of CRHT

It is increasingly clear from our work with local services that admissions avoidance will have a significantly greater impact on bed use than efforts to reduce lengths of stay of those admitted. In too many places, the level of resourcing of crisis resolution / home treatment services is, however, simply insufficient to function as intended, especially outside office hours, such that the service does not offer a realistic alternative to inpatient admission, nor does it gate keep all admissions via proper assessment. Such services can then end up as unpopular with both service users and colleagues from other services, as what they are offering is not "home treatment" in any realistic sense.

Successful crisis resolution / home treatment will gate keep all crises, and offer a genuine 24/7 "ward in the community", essentially along the lines of the Policy Implementation Guide which originally accompanied the introduction of services of this nature. It seems increasingly apparent to us that the lack of this genuine alternative to admission is seriously hampering the functioning of acute mental health care in many locations.

iv) Supported accommodation

There is a mirror issue at the opposite end of the pathway through inpatient care, whereby too many patients have to wait for various forms of supported accommodation to be available. This problem is of course exacerbated by differing budgetary responsibilities, and local authorities' financial pressures are undoubtedly having an effect on their ability to provide social and housing support of this nature. And yet the overall cost to the public purse may well be higher, if this means people occupying acute beds for weeks or months longer than clinically required.

It is worth noting in passing here the implications of this range of local problems for monitoring of local performance. Average length of stay is an extremely poor indicator; reducing overspill and improving home treatment will not reduce average lengths of stay. More meaningful will be the total occupied bed-days, and the length of stay of the top decile and quartile, which could potentially fall if local improvements to acute care services can be achieved.

6. SO WHAT CAN BE DONE? ACTION FOR CONSIDERATION

The first task, we would argue, is to **ensure that the reality of the local situation is properly understood**. What we are seeing at the moment is, in part and too often, the consequence of inadequately thought-through (and perhaps over-optimistic) planning, based on simplistic analysis and unintelligent use of benchmarking data. CCGs are under immense pressure to 'make change happen' and quickly. It is therefore understandable given their limited mental health commissioning resources that planning decisions can be less than thought through. There is nothing "good" about offering the mean number of beds per capita, for example. We all know mental health care service planning is much more complex than that.

We have developed a robust approach to modelling of flows through services, based not on simplistic averages, but on discrete event simulation techniques, which both enable current trends in service use to be projected into the future, and ideas and scenarios to be rigorously tested. This has been used in over dozen economies now. The approach is care-cluster sensitive, and takes account of demographic change, and the characteristics (at a highly detailed level) of current local services and flows between them. We would suggest that all local services should be ensuring their understanding of their current and projected flows is as robust as provided for by this method.

With that understanding, local commissioners and providers will then be able to have a well-evidenced discussion of the local situation, and to address such local priorities as may emerge – be they financial reprioritisation, crisis resolution / home treatment, focused attention on overspill, supported accommodation, or other things of local significance. It is, surely, in no one's interest to see the national headlines and local problems continuing as at present.

If you would like to discuss your local situation please call us.

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