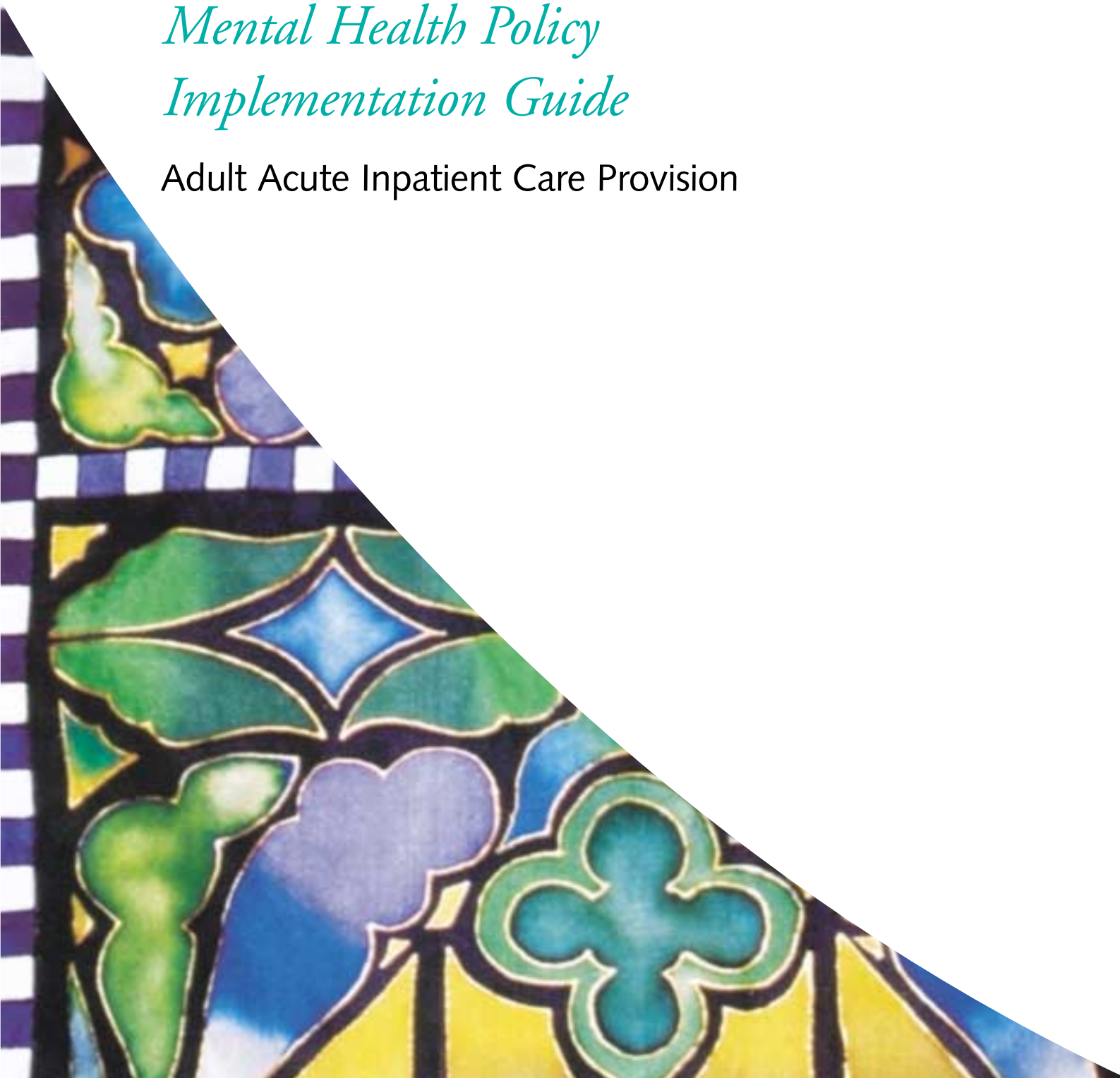
Department of Health

Mental Health Policy Implementation Guide

Adult Acute Inpatient Care Provision



This hand painted silk scarf was designed and produced by Workwise art and design trainees, as a service of commission pieces for Bury St Edmunds and Norwich Cathedral, capturing the striking colours of stained glass.

Based in Bury St Edmunds, Suffolk, Workwise is an Employment Training Centre for people who have experienced mental illness. Workwise offers qualifications, training and development through its various departments.

In the art and design department, trainees receive training in silk painting, textiles and design. There is opportunity to take part in group work, commissions, personal projects and portfolio building. The department produces hand made cards, textile products, silk scarves and banners.

For more information, contact Kate Sparks on 01284 755 261, email info@workwise-suffolk.co.uk

Reflections is the publication supporting the promotion of 'Art Works in Mental Health', a new project that aims to encourage creativity in people who have been affected by mental illness and to promote understanding. We are launching a search for such art to showcase in a variety of ways, including a series of national exhibitions, for non profit purposes.

Entry is open to anyone who has experienced mental illness themselves or has been affected by the mental illness of someone they care about.

You can use a wide variety of media such as painting, drawing, photography, writing, sculpture, pottery and ceramics. Full details are in the application pack. If you are interested, or you know someone who might be, please contact 0870 609 0034, or log on to www.artworksinmentalhealth.co.uk

Art Works in Mental Health is sponsored by Pfizer Ltd and collaborating organisations involved in the project are Breakthrough, Coventry Healthcare NHS Trust, Depression Alliance, NSF, The Northern Centre for Mental Health, South London and Maudsley NHS Trust, PriMHE (Primary care Mental Health Education) and Priority Healthcare Wearside.

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Introduction and executive summary

Acute inpatient care is a core and integral component of the National Service Framework for Mental Health to which all the NSF standards are relevant. Improving adult acute inpatient care and its connections and integration with the other key elements of the whole system of care in its local context is a priority NSF implementation target.

This adult acute inpatient guidance augments existing National Plan and NSF guidance and is a supplement to the Mental Health Policy Implementation Guide. In conjunction with this core acute care guidance supplementary guidance psychiatric intensive care is being issued. Further related guidance on acute care education and training and on substance misuse is being prepared and should be available later this year.

Acute inpatient care should already be a designated high priority by any definition prioritising the needs of people with serious mental illness. It is usually only when people are most seriously ill that they are admitted to an acute care ward. Inpatient provision is still the single element on which we spend the greatest proportion of the adult mental health budget and employ the greatest number of staff.

This guidance is based on user and carer feedback, expert professional opinion and good practice. The good practice examples cited are tangible illustrations of what can be achieved by staff with a real sense of purpose and a passion for developing acute care inpatient services which can match the best of provision in any other inpatient or residential care setting. There are far more examples of such good work than can be cited here, the National Institute for Mental Health in England web site for this guidance will allow regular good practice updates to be produced.

However, too often acute inpatient services are not working to anyone's satisfaction. A range of reports and surveys and the reported experience of service users and staff have clearly and consistently demonstrated a high level of criticism and dissatisfaction with current provision. These shortcomings and concerns are acknowledged and detailed in section 3 of the guidance. It is clear that the physical, psychological and therapeutic environment of care must all be attended to.

To date existing inpatient practice and service delivery arrangements have not received the same focussed attention or policy guidance as the development of the newer community based elements of the acute care system (Crisis Resolution, Assertive Outreach, Respite and Early Intervention services).

In part, this is because it has been necessary to focus on getting effective alternatives to admission established. This major investment in the development of alternatives to admission now creates a very real opportunity to reduce pressure on inpatient wards and to attend in more meaningful ways to the necessary reshaping of inpatient services in a whole systems context. In addition £30 million capital has already been made available for investment in significantly improving the physical environment of acute wards.

The document will serve as a guide to stimulate local action. This guidance aims to encourage and assist a reorganisation of inpatient services for people who are acutely ill which adequately reflects the value base that underpins all current mental health policy. Values need to be translated into appropriate

practice, structure and relationships that promote humane and therapeutic inpatient care in the overall context of continuing service improvement.

The key target areas are:

- To define the purpose and place of adult inpatient care in the context of the National Mental Health Policy whole systems approach.
- To establish effective means of service co-ordination of acute services to provide a safe, structured and therapeutic inpatient experience.
- To develop effective service user centred decision-making processes and ward arrangements.
- To address the need to enhance the role, status, training, support and career development of inpatient staff.
- To direct clinical leadership and management attention and expertise on the organisation and management of inpatient services.
- To ensure adequate clinical and support inputs to inpatient wards and to maximise the time spent by staff therapeutically engaged with service users.
- To promote ways in which future provision can project a more positive and socially inclusive view of mental health.

This guidance is addressed to all involved in acute mental health care; it is inclusive of all adult acute inpatient wards and should be relevant and useful to all who use, work in or commission these services. Implementation will require the creation of stronger partnerships and dialogue between staff, service users and carers, between inpatient and community mental health services and between mental health services and the community served. The focus is not on presenting any idealised picture of inpatient services for those planning new facilities but of recognising the need to deal with the pressures and shortcomings of existing overburdened inpatient wards.

Key to this work will be the establishment of local Acute Care Forums in each Trust to:

- Identify the strengths and weaknesses of current local arrangements.
- To stimulate appropriate action.
- To sustain a momentum of change.

In order to resolve the current lack of research evidence and detailed data on inpatient service operation and use, these Acute Care Forums need to collaborate to undertake a service mapping exercise to identify benchmarks and good practice standards that can provide reliable evidence on which to build continuous service improvement and carry inpatient services positively into the future. This work will be carried out with the support of the National Institute for Mental Health in England's Regional Development Centres who will establish ongoing service improvement and practice development networks explicitly for acute care services.

1. Purpose and aim of adult acute inpatient care

1.1 The purpose of an adult acute psychiatric inpatient service is to provide a high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness. It should be for the benefit of those service users whose circumstances or acute care needs are such that they cannot at that time be treated and supported appropriately at home or in an alternative, less restrictive residential setting.

"[Inpatient] services must be conceived as stepping-stones to inclusion, not departure points for exclusion. The ultimate aim is participation in the mainstream of society for all who desire it."

"Creating Accepting Communities" report of the Mind Inquiry 98/99.

2. Integrating inpatient care within a whole systems approach

Inpatient care is a key component of the National Service Framework (NSF) for Mental Health, yet inpatient care is insufficiently integrated with the community based components of the NSF system of care.

> *"Each service user who is assessed as requiring a period of care away from their home should have timely access to an appropriate hospital bed or alternative bed or place, which is in the least restrictive environment consistent with the need to protect them and the public - as close to home as possible."*
>
> *National Service Framework for Mental Health Standard Five*

2.1 In addition to the need to better define the purpose and content of inpatient care there is the need to define and clarify the place of inpatient care in the context of the NSF social inclusion and whole systems approach.

2.1.2 The need for more investment in alternatives to inpatient admission (assertive outreach, crisis resolution/home treatment, respite care) is already recognised and programmed as part of the NSF and NHS Plan implementation arrangements and these services are rapidly coming on stream across the country.

2.1.3 Too often there is a lack of system co-ordination with many inpatient services having become isolated from the communities they serve and their current and developing community mental health services.

2.1.4 It is now accepted that mental health services are most effective when delivery is within the context of the service users local community. It is important that inpatient services maximise their connections to community services and supports and vice versa. Strong community links are particularly beneficial in the context of cultural sensitivity and responsiveness.

The inpatient service can have a more positive impact if it develops partnerships and maintains liaison and communication arrangements with key agencies in the community (housing, benefits, employment, education, leisure).

2.1.5 A lack of overall service system co-ordination and coherence contributes to the existing pressures on inpatient wards e.g:

- poor throughput;
- inappropriate admissions;
- delayed discharge.

It is essential that there are shared values, principles and processes across the whole service system. There needs to be a clear set of locally negotiated and agreed operational policies covering specifically the entirety of acute care as it stands at present and that will lead on to incorporating the new elements of

service as they come into being. Effective joint working between inpatient care and crisis resolution services are especially important.

2.1.6 These operational policies should be published and made available locally for referrers and all stakeholders and must be clear and consistent about process and responsibilities regarding:

- Referral and admission criteria.
- Community treatment and support options.
- Continuity of care arrangements.
- Managing bed and alternative service availability.
- Inpatient treatment and care options.
- Links and support to inpatient services.
- Managing risk.
- Creating and maintaining a safe environment for users, visitors and staff.
- Links to both child and adolescent and older peoples services.
- Communication standards.
- Out of hours on call system to provide support, advice and guidance.
- Dispute resolution.

The majority of these issues are interdependent.

2.1.7 Each NHS Trust must establish an Acute Care Forum, with links across the elements of the acute care system (to include intensive care) and with involvement of service users and carers to agree and regularly review the operation and co-ordination of the range of acute care services. The scope and remit of the Acute Care Forum is detailed in section 8. This forum should locally operationalize important issues around effective service co-ordination and delivery, paying particular attention to acute working and interface practice issues between crisis/home treatment teams and inpatient wards. This forum should report to the Clinical Governance Committee of the Trust, be linked to the NSF Local Implementation Team and Local Modernisation Review and should collaborate with other trusts in the region, Strategic Health Authority to build continuous improvement in acute inpatient services.

3. Problems with current inpatient provision

3.1 While there are many excellent inpatient services with dedicated professional staff, there is however incontrovertible and compelling evidence, particularly from service user feedback to indicate that too often the experience of acute inpatient care is felt to be neither safe nor therapeutic.

3.1.2 Service users report serious concerns regarding:

- A poor physical and psychological environment for care, including lack of basic necessities and arrangements for safety, privacy, dignity and comfort.
- Insufficient information on their condition and treatment and on how the ward and service operates.
- Lack of involvement and engagement in the planning and reviewing of their own care and in how the ward is run.
- Inadequate staff contact, particularly one to one contact with staff.
- Insufficient attention to the importance of such key factors as ethnicity and gender and protection from harassment/abuse.
- Lack of 'something to do', especially activity that is useful and meaningful to recovery.

3.1.3 For many service users previous experience of acute inpatient ward conditions and practice is such a negative experience that they may try to avoid contact with mental health services when acutely ill for fear of admission. Such negative experience may also contribute to premature discharge placing individuals at risk. Loss of contact with service users when they are acutely ill is in itself a significant risk factor and a weakness in the current organisation of many services.

3.2 Key factors contributing to those service user concerns have been identified, in a number of local and national reports and at events looking at improving inpatient care. While there is considerable variation across services nationally, the following service deficits are relatively common.

- Lack of clarity of purpose and a clear service framework for inpatient care.
- Over pressurised inpatient staff having difficulty in maintaining a consistent therapeutic engagement with service users in inpatient settings.
- A qualitative change in the patient profile e.g. an increase of complex presentations involving substance misuse; personality disorders.
- Diffuse and therefore more likely to be ineffective clinical/managerial leadership and co-ordination.
- Insufficient availability of alternative acute care services and system support.
- Inability to identify and therefore respond appropriately to early signs of individual or group disturbance which may lead to incidents of violence or aggression.
- Poor physical environments, overcrowded wards; units/wards too big, bed occupancy too high.

- Poor co-ordination and communication across the system of care.
- Lack of systematic, evidence based approaches to inpatient episodes of care.
- Poor clinical supervision, staff support and professional development arrangements for ward staff.
- Too great a reliance on bank and agency staff.
- Lack of multi-disciplinary professional input to treatment programmes for inpatients.

4. Reshaping the service

Reshaping the organisation of inpatient services to provide a more effective, safe and therapeutic inpatient experience, built around the needs of service users, their families and carers is a NSF priority.

4.1 Philosophy of Care

The philosophy of care needs to be explicitly user focused.

Each Acute Care Forum should define the therapeutic philosophy and overall service framework of acute inpatient care with specific written service criteria on the purpose and nature of the service provided and the nature of the work, skills, knowledge and attitudes expected of staff.

4.1.1 As with the other NSF system of care services (early intervention, crisis resolution, assertive outreach, CMHTs), there needs to be a clear service user focus on safety, recovery, engagement, social access and inclusion. The increasing proportion of service users who are more likely to be severely ill and have greater social needs has increased the need for clarity of purpose and clear care pathway arrangements.

4.1.2 Team/ward based systems need to be established that recognise and acknowledge the challenges to delivering effective therapeutic care to a number of service users with often complex needs in the most acute phase of their illness. These systems need to be able to reflect on the effect that being in this environment has on both the staff team and the users on the ward at any one time.

4.2 Inpatient Care Pathway Arrangements

"All mental health service users on the Care Programme Approach (CPA) should receive care which optimises engagement, prevents or anticipates crisis, and reduces risk."

National Service Framework for Mental Health Standard Four

4.2.1 Therapeutic purpose and operational arrangements of each inpatient unit need to be determined in the specific local adult acute service system context with explicit care pathway arrangements both into, within and out of inpatient care. These arrangements need to be negotiated, agreed and managed across the components of the service system and signed up to by key stakeholders via the acute care forum.

4.2.2 The care programme approach applies to all those people who are under the care of secondary mental health services (health and social care), regardless of care setting. Effective care planning provides an ongoing framework for properly assessed and co-ordinated care and risk management; service user and carer involvement and communication amongst disciplines and across care settings.

However, care planning arrangements in too many inpatient units are confined to admission and discharge arrangements. They are not sufficiently clear on the process of assessing, planning and delivering inpatient care itself or the expectations of the service user while an inpatient. Inpatient care planning should include continuity with CPA care co-ordinators, with existing care plans available to inpatient staff.

4.2.3 Inpatient care is a time when service users must have their needs specifically planned and provided for; it must not be a respite from having an individual care plan. Given that referral to inpatient care is

implicitly a request for more urgent and/or intensive intervention, there then needs to be greater urgency and clarity regarding inputs and interventions required, how they are going to be delivered and what is to happen after the course of inpatient treatment is complete. It is key that inpatient treatment's specific purpose for and expectations of that individual service user are addressed as part of the overall care plan.

4.2.4 Assessment, care delivery and discharge planning should include crisis intervention/home treatment teams where appropriate, eg where admission follows a period of home treatment input. With increasing gate-keeping of acute presentations by crisis/home treatment teams the potential for collaborative acute work even after admission has occurred needs to be recognised. Further joint working during inpatient phases, can support leave and facilitate early discharge.

4.2.5 With the involvement of the service user (and carer/family if possible) an initial short term collaborative care/treatment plan should be agreed, if not before or on admission then as soon as possible afterwards. Service users must be given a written copy of their own care plan.

4.2.6 Effective service user centred assessment of needs and risks must be carried out using established procedures and assessment tools for measuring symptoms, risk and social functioning. It is important that these procedures are relevant, standardised and streamlined to minimise unnecessary paperwork and protect time available for direct patient contact.

4.2.7 Risk assessment should focus not only on the inpatient care phase but should look at community living and include risks to the service user, eg loss of income, housing, stigma. A joint assessment between community and inpatient teams improves accuracy and comprehensiveness.

4.2.8 Assessment must also include often neglected areas of physical care, dietary requirements and spiritual needs. Levels of physical morbidity amongst users of mental health services are well documented, and it is therefore essential that a full physical examination is undertaken on each admission. Expert advice should be sought from specialist services when specific conditions are already established or identified in the course of assessment. E.g. diabetes; coronary heart disease; epilepsy; in order to inform care plans, regular reviews and ongoing treatment regimes.

4.2.9 The need for thorough assessment to maintain the service users place in the community and to prevent inappropriate lengths of stay in inpatient care make it important that community services and resources are engaged and mobilised at the earliest stage. Planning for discharge and support after inpatient care should commence in the initial care plan. This should involve crisis intervention/home treatment teams to facilitate early discharge.

4.2.10 There needs to be absolute clarity regarding the processes and communication of care planning and delivery for each ward/unit. Integrated care pathway documentation must be agreed to enhance care delivery and communication across the range of acute care services. Care pathway policy needs to be specific about gate-keeping and use of alternatives to admission.

4.3 Admission and Reception

"Small things make a big difference, not just because of practical needs being met but because of how the service values you … that bulb changed, decorating the ward… being asked your opinion"

Barbara Crosland – User Voice, South Birmingham.

4.3.1 The reception of service users to inpatient care requires greater sensitivity to the impact of psychiatric hospital admission for the individual, and to family/carer anxiety and needs at this time.

4.3.2 Service users report that the process of admission can in itself be a distressing and demeaning experience. Too often the first days of an inpatient stay are particularly confusing and boring with the service user and their family not knowing what is available or what is expected of them.

4.3.3 This concern increases the need to place great emphasis on early assessment and initial care plans to see what therapeutic activities and interventions may be organised and accessed and so any immediate risks, anxieties and concerns may be dealt with and appropriate reassurances given.

4.3.4 The first 72 hours seem particularly important in an individual's admission, requiring orientation, guidance, information, engagement, and reassurance – all of which must be informed by the vulnerability, capacity and accessibility of the individual at that point.

4.3.5 Information needs to be provided in an appropriate and accessible format on privacy and confidentiality, accessing help, getting information, housekeeping and related ward arrangements. There needs to be clear arrangements for orientation to the ward environment and contact arrangements for accessing the personnel involved in the service users care. Service users must be informed and regularly reminded of their legal rights regarding treatment choices and consents under the Mental Health Act.

4.3.6 Consideration and provision must be made for the sensitive and appropriate reception and orientation of service users with specific needs (ethnic minority communities, people with disabilities…).

4.3.7 All services must have clear written and active policy on dealing with racial or sexual abuse or harassment.

4.3.8 Inpatient services must facilitate and promote service user access to advocacy and interpreting services. Access to advocacy services is particularly important regarding identifying and resolving service user and family concerns at the point of admission.

4.3.9 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.

4.4 Structuring Inpatient Care Arrangements

Oakburn ward, Bradford

Over the last three years, Oakburn ward has undergone powerful change.

In the past, the ward was chaotic, noisy and dirty. Nurse patient relationships were not well established and yielded little benefit. Nurses had little time for anything other than servicing routine observations. Violence, self injury and absence without leave were high, documentation was poor and the staff exhibited poor morale and high sickness.

Now the picture is very different. 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.

4.4.1 High therapeutic intervention and interaction environments diminish disturbance, violence and boredom. Poor amenities and lack of structured activities and individual attention promote untoward incidents and create risks. Inpatient units that provide appropriate stimulation and structure as part of individual care plans have a more therapeutic and safe environment. Yet a recurring theme in most reports on inpatient care is 'lack of something to do' (as one report put it "a sort of suspended animation").

4.4.2 Many inpatient services are inadequately structured or resourced to allow effective therapeutic engagement of service users. Inpatient nursing and related care depends primarily on relationships; staff need to have the time to talk with and listen to service users and carers. Ward arrangements need to be organised and structured to foster a milieu and culture of engagement and to maximise the time that staff spend therapeutically engaged with service users. Activities that detract from therapeutic time should be reviewed. Each inpatient service needs to have a clear focus on the timetabled accommodation of therapeutic activity and engagement of service users, both on and off the ward.

4.4.3 There must be regular means and forums for encouraging service user involvement in determining how the ward is run, what rules of conduct apply and what activities are available. Each ward should have regular timetabled user/staff meetings with advocacy input as requested.

4.4.4 Attention must also be paid to the interpersonal consequences of service user behaviour on the ward. A code of conduct should be drawn up identifying clearly unacceptable behaviour such as racial or sexual harassment, theft etc. This code of conduct should also cover ward rules, negotiated with service users, regarding housekeeping issues such as management of noise (TVs, radios, etc) and how disputes over such matters are to be resolved.

4.4.5 Ward arrangements should facilitate contact, input and joint work with the normal sources of mental health, social support and self esteem that service users access in the community e.g. family/carers, mental health and primary care support. More creative responses to service user needs for therapeutic, social and recreational activities during inpatient care need to be developed and need to be supported by inreach from multi-disciplinary teams and other community support services, including voluntary and non-statutory services.

> *"Carers play a vital role in helping to look after service users of mental health services, particularly those with severe mental illness. Providing help, advice and services to carers can be one of the best ways of helping people with mental health problems."*
>
> *National Service Framework for Mental Health Carers Quote*

4.4.6 A key factor contributing to a sense of boredom and lack of service user engagement on inpatient wards is inadequate clinical input to the ward from the full range of care professions that comprise the mental health multi-disciplinary team. There needs to be commitment from provider organisations and the relevant professional groups to target multi-disciplinary input to evidence based treatment programmes for service users on the ward and to contributing expertise to the effective organisation of the ward as a therapeutic enterprise. This input needs to be planned, consistent and reliable and not dependant on the interest or enthusiasm of individual practitioners.

4.4.7 There is a range of evidence-based interventions and skills that are particularly relevant to inpatient work, but are infrequently available in inpatient settings. Given the serious mental illness status of service users in acute care they should have a priority access to these interventions (family and carer support interventions, medication management strategies, coping strategy development, risk management and safety interventions…).

4.4.8 Meaningful activity should be determined within an individual care plan negotiated with the service user. Occupational therapists have a specific expertise in assisting this care planning and in the determination and facilitation of a range of appropriate activity inputs onto the ward.

Some of these interventions need to be adapted and specifically modified to practice within the constraints of working in an inpatient setting where an increasing number of service users are detained and many compulsory inpatient stays are of a relatively short duration.

With clarity of whole system working and clear care pathways many of those interventions can be continued post discharge.

4.4.9 Clinical psychology input needs to be increased to assist ward staff with the acquisition and practice of the necessary skills and to input into group and individual treatment and care arrangements. The therapeutic value of effective ward community groups, involving experienced staff (from all disciplines) should be considered as part of any inpatient therapeutic milieu. These groups have the potential to contain and anticipate disturbance, use the resource of other users and offer opportunities for reflection and insight.

4.4.10 There should be regular pharmacy input to inpatient wards to educate staff and service users in medication management skills. Consistent pharmacy input and membership of the acute care forum should be encouraged.

4.4.11 Social work input to effective care planning for inpatients and clear working arrangements with social services and related local government services are critical to meeting needs of service users and maintaining their support networks in the community.

4.4.12 In addition the need for access to and regular input to the inpatient ward and its organisation and activities by physiotherapy and dietetics needs to be clearly defined, understood and deliverable.

4.4.13 The creation and maintenance of a therapeutic activity milieu needs to include evening and weekend activities and opportunities both on and off the ward. This may include educational, social, artistic, recreational and leisure activities.

4.4.14 There is currently an imbalance of emphasis and deployment of staff skills in organisation of inpatient wards. Such activities as record keeping, ward rounds/reviews, observation, can inappropriately monopolise staff time, when compared with therapeutic engagement. It is important that adequate priority and resources are given to a structured regime of activity and service user engagement and that staff skills and time allotted to such work is protected in the face of competing demands.

4.4.15 Each ward should have specific ward based clerical/administrative support covering the 24-hour operation of ward.

4.4.16 Clarity about the aims, timing and organisation of regular clinical activities such as ward reviews, medication and formal observation should be agreed in consultation with service users. Written protocols for the provision of these services should be agreed.

"Do something about the dreadful ward rounds and the queuing up for medication like naughty school kids waiting to see the headmaster."

Sarah King, Impact Research Team

4.4.17 Current arrangements for the dispensing of medication on many wards need to be improved to facilitate service user privacy, dignity and confidentiality.

4.4.18 In the interests of safety and to minimise risk there is a need to place particularly vulnerable service users under formal observation. The National Confidential Inquiry Report has shown that there is an increased risk when observation policy and practice are not clear or sufficient. Services and clinical teams need effective and sensitive protocols for the practice of supportive observation and positive opportunities for engagement.

These protocols should include seeking service user views with an emphasis on maintaining as much personal responsibility and engagement as possible. Reasons for the instigation of observations should be explained.

Many service users find the experience of being formally observed intimidating and for some it may be counter-therapeutic.

The thresholds for placing and keeping service users on formal observation need to be clearer. If thresholds are too low then staff time that could more positively be targeted on more therapeutic engagement will be misdirected and the ward culture is more likely to be custodial in nature.

4.4.19 Services should audit and review existing arrangements for the prevention of suicide, ensuring that staff are competent to assess risk of suicide and know what action to take if they are concerned. Prevention of self-harm protocols and training based on the forthcoming suicide prevention strategy and the NSF standard 7 toolkit should be developed.

4.4.20 Overall there must be absolute commitment to service user and staff collaboration in running the inpatient ward. Reshaping the inpatient service and ward arrangements around the needs of service users and their families/carers cannot be done without robust means for the ongoing encouragement and facilitation of service users to voice views and concerns. (Similar, but not necessarily the same forums/means are needed to ensure effective carer input). There should be clear arrangements and support to facilitate service users giving feedback, raising concerns and agreeing ways of making improvements to the organisation of the ward.

Eileen Skillen ward, Brixton

The emphasis on ES3 ward is on leadership and maintaining an inclusive, respectful, learning culture for service users, staff and family and friends.

The ward serves the catchment area of Brixton and about half of service users are admitted with psychosis, schizophrenia and/or personality disorder. 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 of the ward to asking ex patients to participate actively in staff interviews.

To help encourage staff recruitment and retention, the ward provides offers 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.

4.5 Leadership and Management Issues

"A deficit of clinical leadership in inpatient settings is one of the root causes of the failure to provide therapeutic care for the acutely ill."

'Addressing Acute Concerns' SNMAC – June 1999.

4.5.1 In rethinking the organisational arrangements for inpatient care addressing the question of leadership is a matter of priority. The process of achieving the changes outlined in this guidance must be clinically led and sustained with clearly identifiable clinical and professional leads for each local inpatient unit and ward.

4.5.2 Lack of leadership focus on inpatient service structure, delivery and system co-ordination exacerbates over-occupancy and over pressurised ward environments thus prompting a more custodial and less engaging and therapeutic model of inpatient care.

In each local area there is a need to target expertise and leadership on the organisation and clinical management of inpatient care and on the co-ordination of care across the acute care system.

4.5.3 Opportunities to develop nurse consultant and other specialist posts to lead practice development in adult acute care with a specific focus on working in and improving inpatient care should be exploited.

4.5.4 The Modern Matron initiative provides opportunities to secure and assure effective leadership for inpatient staff, ensure high standards of administrative and support services to the wards and provide a visible, accessible and authorative presence in inpatient settings for service users, carers and staff to turn to for advice and support.

4.5.5 The role of the nurse in charge of the ward needs to be reviewed and strengthened. She/he should be the point of contact for consultation, negotiation and decision making for all ward organisational matters. There needs to be investment in the development of managerial and leadership competencies of ward managers or sister/charge nurses.

4.5.6 Consultant Psychiatrist and medical staff arrangements exert great influence over inpatient services and their organisation. While inpatient care needs a multi-disciplinary partnership approach, development of joint medical and nursing practice is particularly critical to staff deployment and managing risk on each ward, and to overall inpatient service development and co-ordination.

Too many of our inpatient wards have multiple consultant psychiatrists involved without any of them having a specific responsibility for how the inpatient ward/service as a whole operates. Each inpatient ward/service must have its own dedicated lead consultant psychiatrist who can provide expert input into key matters of inpatient service delivery, staff support and supervision, and overall acute care service co-ordination.

Specific sessions should be set aside in consultant job plans to ensure sufficient time is available for their consistent and regular input to the ward team and related forums.

4.5.7 The SHO and staff grade psychiatrist role and responsibility should also be clarified to emphasise the importance of their assured input to care on the ward.

5. Inpatient care staff

5.1 The role of staff working in the inpatient ward setting needs to be strengthened and more highly valued. The aim is to provide quality inpatient services with active therapeutic engagement by well-led, competent, motivated and skilled staff. It is recognised however that at present there are severe problems in the recruitment, retention and training of skilled practitioners from all disciplines in inpatient care settings.

5.2 Enhancing the Role and Status of Inpatient Nurses

Shortages of staff, lack of the skills, attitudes and knowledge required, high staff turnover, and over-use of bank and agency nursing staff, all contribute to low staff morale and mitigate against the development of a safe and therapeutic ward culture. There is an urgent need to enhance the specific role and status of inpatient acute care nurses in the context of the overall system of care and to develop this area of acute care expertise so that it will attract and retain high quality nursing staff.

5.2.1 Inpatient services need nursing staff, sufficient in number, who are confident of their skills and have the time and competence to intervene therapeutically. There is strong evidence that as the acuteness of the inpatient population has risen the time, expertise and skills targeted on inpatient services have diminished. Given the relatively low status and grading of ward staff compared to community mental health staff it is not surprising, that many nurses have simply voted with their feet and left inpatient care for higher status and better rewarded jobs. Unless these trends away from inpatient nursing are reversed, action to bring about improved and more therapeutic inpatient services will not succeed.

5.2.2 There is a need to attend to the career structure and re-examine the grading of nursing posts in mental health services so that services invest in encouraging nurses to work in inpatient settings and across the acute care service. Modernising the NHS pay system is a key target for the "NHS Agenda For Change" to ensure staff are fairly rewarded and to help procure the service improvements required for patients. It is acknowledged that there is a need for consistency across the whole of the NHS and the scale of investment required for overall NHS pay reform is an issue beyond the scope of this guidance. The restructuring needs to ensure that new pay and grading arrangements better recognise the importance of the skills and experience required for inpatient work. Attention needs to be given to improved career structure and incentives across the full complement of inpatient nursing staff grades. The grading of mental health staff from all disciplines should act as an incentive to their deployment in inpatient settings.

5.2.3 Whereas community mental health nurses are properly recognised as specialists there is little recognition of the specialist expertise and skills, knowledge and attitudes required of nurses working in inpatient services. The key competencies of the inpatient mental health nurse and other inpatient staff need to be defined and incorporated into grading criteria and training packages.

In conjunction with this implementation guidance, further guidance is shortly to be issued on the core principles, content, delivery and monitoring of education and training required.

5.2.4 Options for the single management of acute care services, in particular of each locality's inpatient and home treatment service staff, should be considered. This can facilitate the induction, deployment, secondment and training of nursing and other acute care staff across the hospital and community elements of the service and foster an appreciation of the interdependence of inpatient and community

acute care. A positive policy on rotation of staff could help prevent/reduce barriers arising between services.

5.2.5 With the advent of new community acute treatment options there are local opportunities to improve service coherence and co-ordination by the creation of acute care nursing posts that work in both the inpatient and community treatment teams and that facilitate creation of better graded and higher status nursing posts. In addition to nurse consultant and management posts this should include posts across the spectrum of current grades and levels of experience.

5.3 Inpatient Staffing Levels

5.3.1 Too many inpatient wards do not have the levels of staff and skills available to deliver the required standard of care and as such the quality of the worklife of inpatient staff is constantly compromised. In some cases this is due primarily to an inability to fill vacancies and the resultant over reliance on temporary staffing. In others it is due to staffing establishments that are inherently inadequate to provide quality inpatient care.

5.3.2 Quality care is dependant on effective relationships not only with service users but also between staff. There needs to be a stable and consistent inpatient ward team, staffed to accommodate the needs for structured therapeutic service user engagement, staff training, supervision and practice development in addition to the more formal or routine duties of ward staff. Indeed there is evidence from some services that staffing levels incorporating structured engagement and practice development can considerably diminish the use of bank and agency staff, improve morale, recruitment and retention of staff and be more acceptable to users.

5.3.3 There are clearly difficulties in providing a focused therapeutic ward regime when there is an over reliance on bank and agency staff. Each service needs a clear and written policy on the recruitment and use of bank and agency staff including:

- A system to ensure staff have the basic skills, attitudes and competencies required.
- Proper arrangements for the induction and management of bank and agency staff.
- A system to routinely monitor and report on the use of bank and agency staff.

5.3.4 Effective systems for rostering staff who know the patients best, and deploy skills appropriately are required. Too often it is qualified nurses who are dealing with the burden of paperwork and related office responsibilities while it is largely bank and agency staff, students and non-professionally qualified staff who are with the patients.

5.3.5 Services should undertake specific initiatives to encourage the employment of staff from the range of ethnic backgrounds that reflect the ethnic profile of the patient and catchment area population.

5.3.6 Effective staff support, management and clinical supervision arrangements must be in place. These arrangements need to include follow-up support for staff involved in distressing or untoward incidents.

5.3.7 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. Further consideration should be given to the development of such new mental health worker roles as “support, time and recovery worker” posts (STaR workers) to facilitate better organisation and availability of therapeutic and related activities.

5.3.8 We do not make specific recommendations on the nursing establishment required for an inpatient ward. There is no simple formula for calculating the nursing and multi-disciplinary staffing requirement. This is influenced by a number of complex factors, such as ward size, the configuration of local services, existing staff skills, the availability of support. Needs are not static and are subject to local variation. The work of Acute Care Forums and collaborative development networks will identify appropriate staffing establishment benchmarks as an early priority in implementing this guidance.

5.3.9 While we are not in a position to recommend any specific staffing establishment requirements it is clear from the evidence and feedback from service users and staff that many of our inpatient wards do not have appropriate staffing levels with the skills required to achieve the necessary standards of care. Commissioners of inpatient services will need to review current establishments, informed by benchmarking exercises, and in many cases will need to direct significant extra investment into inpatient services, staffing and training to overcome current serious service deficits.

5.3.10 Inpatient services need to work together using their acute care forums to establish benchmarks that reflect NSF core values and provide a sound evidence base to develop policy, inform commissioning decisions (staffing levels and inputs, balance of provision, lessons learnt… etc) and local NSF local implementation teams. Each commissioning body should carry out an annual review of its acute care services informed by such benchmarks.

"Respondents spoke of both good and bad practice, with experience of very supportive and understanding staff who actively aided recovery, to staff who made patients feel like a "nuisance" and seemed to spend most of their time away from patients."

'Environmentally Friendly', Mind 2000.

5.4 Education and Training of Inpatient Staff

Specific guidance on education and training of inpatient staff is being produced in conjunction with this report and will be issued later in 2002.

5.4.1 In order to improve recruitment and retention of sufficient staff in inpatient services with the skills, knowledge and attitudes required, action needs to be taken to identify and overcome barriers to the education, training and continuing professional development of inpatient staff. There are insufficient programmes, courses and opportunities aimed at inpatient staff and pressure of work too often means inpatient nurses in particular are unable to be released to attend the courses that are available.

5.4.2 Innovative training and education programmes specific to acute and inpatient care should be developed. Training and education for acute inpatient mental health workers needs to adapt to the NSF whole system of mental health care and the emergence of evidence based care and treatment. Values and attitudes need to be realigned with a specific emphasis on service user and carer participation, structured engagement, purposeful evidence based interventions and whole system care co-ordination. Training and education programmes must ensure they can impart the specific knowledge and skills required to deliver this agenda.

5.4.3 In order to competently meet the requirements of their existing roles and planned developments inpatient services need to ensure staff can undertake training in these key areas. There is a need to recognise undertaking this training is part of the job "a real workfactor." Adequate training time must be planned and programmed in for all ward staff.

5.4.4 Time should be identified within the working week for an ongoing programme of structured multidisciplinary learning opportunities both on and off the ward. A culture of learning from the day to day experiences of working with users and their families should be promoted and aspired to. The Acute Forum in each organisation should address how systems that would support such a culture can best be reviewed or created. For example, case review meetings, structured handovers, clinical discussion groups – all examples of creating a space that allows for reflection, thinking and understanding and the thoughtful application of skills, knowledge and timely interventions. Such a culture could also be supported by external practice development initiatives to develop, share and promote good practice.

5.4.5 Nationally recognised, high status training programmes need to be developed that lead to specialist qualification in acute inpatient mental health care.

5.4.6 The delivery of education and training needs to become not only more innovative but also:

- More inclusive of service user and carer training roles.
- More integrated into everyday practice.
- More integrated into service monitoring and governance.

"Boredom makes people worse – more ill -, situations escalate in mental health units like they do in the taxi ranks."

Laurie Bryant, Impact Research Team

6. Specific issues

6.1 Improving The Physical Environment of Care

Collingwood Court ward, Newcastle

A newly built ward, Collingwood Court 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
- 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. A carers' support network, also held once a month, has been evaluated as very useful and the ward has been independently hailed as an area of good practice by Breakthrough.

6.1.1 Poor standards of design, lack of space and access to basic amenities and comforts in much of our current inpatient provision have contributed to and reinforced service users negative experiences of inpatient care as unsafe, uncomfortable and untherapeutic.

6.1.2 Standards for acute mental health wards need to be at least equivalent to those required for any other NHS inpatient provision. Given that the design and physical appearance of the ward acts as a tangible statement of value to service users, carers and staff, it may be argued there is a greater need.

6.1.3 DoH guidance has been issued on improving safety, privacy and dignity on mental health wards. This guidance contains specific advice to provide separate women only sleeping, washing, sanitary and dayroom accommodation. Providing a safer and therefore more therapeutic physical environment of care for women is a high priority. Appropriate zoning of accommodation offers an alternative to separation on the scale of a whole ward and may facilitate provision of single sex accommodation in smaller more local mental health inpatient provision.

6.1.4 Inpatient wards/units need to be risk averse environments. In the context of maintaining a safe, service user centred environment, regular audit and detailed risk assessments, involving service user views, should take place to reduce and monitor any environmental dangers in the design, equipment and organisation of the ward.

6.1.5 Environmental factors, i.e. cramped conditions and lack of privacy are linked to violent incidents on wards. There needs to be a greater availability of appropriate space and facilities to stimulate therapeutic engagement, social interaction and recreation. Where adequate space, light and ventilation are not available on the ward then steps need to be taken to reassess room allocation and space utilization to address this problem.

6.1.6 Service users need to be able to leave the ward to attend activities elsewhere in the building and to access usable outdoor space.

6.1.7 Activity space is required both on and off the ward. Multi-purpose activity space needs to be available each day of the week. Too often in existing provision potential activity areas are not made available in the evenings and at weekends and/or they are seen to be exclusively for weekday therapeutic activities. Community and service user organisations should be encouraged to provide services and activities making use of such facilities.

6.1.8 In addition to private toilet, bathing and washing facilities, arrangements need to be in place for ensuring privacy for service users to make phone calls, receive visitors or just be alone. Provision also needs to be made for the safe and accessible storage of personal belongings and valuables.

6.1.9 Improved standards of furnishings, equipment, cleanliness and decoration need to be provided and maintained in line with NHS Plan targets. Maintenance and refurbishment arrangements for acute inpatient wards need to recognise the additional wear and tear such wards experience.

6.1.10 There is a need to improve the mealtime experience of service users in line with the recommendations of the NHS Plan Better Hospital Food Initiative, while paying attention to the specific needs of mental health service users.

6.1.11 Service users need to be offered greater influence over catering arrangements and choice of food. This is particularly important in ensuring the cultural appropriateness of arrangements.

6.1.12 Service users should have access to drinks and refreshments at all times.

6.1.13 Provision including access to a private space and refreshments should be made to encourage and facilitate carer and family involvement and visiting. A children' s visiting policy should be in place.

6.1.14 Innovative implementation of support roles such as the ward housekeeper initiative can assist in the creation of a more comfortable ward environment.

6.2 Acute Inpatient Provision for Women

"There needs to be more places like the Women's Service. I have benefited greatly from my stay and I am sure a lot of other women should benefit. I was treated with kindness and respect, and my care plan was based around what I told the nurses about my needs. I found this much different to my stay at hospital. Nobody spoke down to be here and there was always a member of staff for me if I needed to talk or was upset."

Women's House, Croydon

6.2.1 The single most important issue for women service users is a sense of proper arrangements being in place to ensure their physical and psychological safety.

6.2.2 Each acute service should provide a self contained women-only inpatient unit and clear criteria for admission should apply. Consideration should also be given to alternatives to inpatient admission eg women-only crisis house, crisis resolution/ home treatment.

6.2.3 Patient conduct protocols should be in place to deal with the unacceptability of men treating women in a negative or damaging way.

6.2.4 Staffing arrangements need to ensure women have adequate access to women staff at all times, particularly with regard to choice of keyworker, control and restraint, physical health care and counselling.

6.2.5 All monitoring of acute service use should be undertaken by gender (and ethnicity).

Anam Cara Crisis House, Birmingham

Anam Cara crisis house in 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.

The DoH will be issuing a national women's mental health strategy in 2002.

6.3 Psychiatric Intensive Care Units

Pathways Psychiatric Intensive Care Unit, North East London

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.

Specific guidance and detailed standards for psychiatric intensive care units have also been issued with this guidance.

6.3.1 Psychiatric intensive care units (PICUs) are highly structured locked units, usually between 6 to 15 beds. Every acute inpatient facility should have access to an identified PICU in their area. Patients, who cannot be safely managed and successfully engaged on account of their behavioural disturbance, resulting from mental illness, on open acute wards should be considered for referral to PICUs. This should be done after all possible strategies to effect positive change in such disturbance have been tried

on open acute wards (such as de-escalation, therapeutic activity programmes, adequate medication regimes including rapid tranquillisation, adequate nursing support and interventions and other multidisciplinary input). Good liaison between acute inpatient services and PICU is essential. The general philosophy of treating and managing patients in the least restrictive environment, as close as possible to their homes, must be followed.

6.3.2 PICUs should have a clear, well-defined operational policy. Due to the high levels of disturbance on these units, it is essential that patients remain on these units for the shortest time necessary, usually 4-12 weeks. As part of a core service, PICU should have a specifically allocated and skilled multidisciplinary team. Staff to patient ratio is typically higher in keeping with the intensive care delivered in these units. Admission and discharge criteria should be well defined to prevent inappropriate admissions, long length of stays for patients and delayed discharges.

6.3.3 Effective PICUs should have a comprehensive range of multidisciplinary activities and an intensive therapeutic intervention programme, underpinned by a core philosophy of risk assessment, management, and intensive engagement; such as very high levels of one to one staff to patient interaction by nursing, psychology, occupational therapy, social work, pharmacy, medical staff in addition to other therapists in a humane environment. Following this intensive care, it is expected that patients will return back to a less intensive environment as appropriate to their needs, typically open acute awards.

6.3.4 PICUs should have a clear identity and a defined primary role in providing support to the local general adult acute inpatient facilities. This should also include a locally derived understanding of the levels of risk they are effectively able to manage with established criteria for referral to forensic services and interface with the criminal justice system.

7. Commissioning future inpatient provision

7.1 Levels of Inpatient Provision

The principal focus of this implementation guidance is on how to address the pressing need for service improvement and change in our existing acute inpatient services within current levels of bed provision and within the constraints of the current estate. It is about how to ensure our inpatient wards have the resources, skills, attitudes, attention and connections to operate effectively and take their service forward.

7.1.1 We have not put forward recommendations on the number of acute inpatient beds required. The need at this time is to concentrate on how our existing services can be improved rather than arguing for more (or less) of the same. The appropriate level of inpatient bed provision can only be properly ascertained in the context of greater clarity regarding the effective use of inpatient provision and the other NSF acute care components (crisis resolution, respite care) and of local needs and circumstances.

7.1.2 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.

7.2 Buildings and Locations

"There is currently a need for new, smaller, more domestic acute inpatient psychiatric units. These must reflect current practice and be of a standard which is likely to be acceptable to patients and staff well into the middle of the (21st) century."

Not Only Bricks and Mortar

7.2.1 The setting people are treated in alters the dynamic of the therapeutic relationship both at an individual and at a service level. Treating people in more inclusive and engaging settings positively alters the dynamic of the staff/service user relationship and the mental health service relationship with other key health, social care and community services. Inclusive settings can positively influence the public perspective of mental illness and diminish stigma and discrimination.

7.2.2 It is important that the buildings and the physical environment for acute mental health services reflect a positive vision of mental health as a normal part of the health service and the life of the community it serves.

The self-image of acute inpatient mental health services and how it is projected is powerfully made by the nature and location of buildings we provide services from. More attention needs to be given to designing safe mental health inpatient services that are located to purposefully engage the community served and respond to its needs.

7.2.3 For those planning new inpatient provision there is an opportunity to plan and provide buildings that in design and location promote service partnerships, social inclusion and mental health promotion.

7.2.4 Consideration should always be given to what needs can be met locally. This is particularly important in providing culturally sensitive services to ethnic minority communities.

7.2.5 Buildings can be used to better connect mental health service elements together (acute inpatient and crisis resolution services) and to connect mental health with the wider network of primary care and community health resources. Joint developments in non institutional settings with primary care services will assist service access, coherence and reduce stigma and exclusion.

7.2.6 Some acute inpatient services will due to critical mass or specialist nature, require separate sites or will be part of an overall hospital development. It is nonetheless important that these units also adopt a community involvement focus and seek to maximise key connections to community resources. Too many of our existing inpatient wards are too isolated from the community components of the system of care and the ordinary life of the community served.

8. Developing and sustaining improvement

In order to implement the key themes of this guidance:

- Integrating inpatient care into a whole systems approach
- Informed and involved service users and families/carers
- Social inclusion and connection
- Clinical effectiveness
- An enhanced role and status for inpatient staff
- Education and training
- A structured activity and engagement focus
- Multi-disciplinary and inter-agency working
- Sensitivity to gender and cultural needs
- A safer and more comfortable environment of care

We need to build expertise, leadership and excellence in acute inpatient care and to ensure that this work receives guaranteed attention and priority at all levels of the mental health system.

8.1 Acute Care Forums – Service Mapping/Ward Profiling

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.

There are few quick and simple remedies. Sustained effort and collaboration across current services is required to identify priorities and tailor services and practice improvement to local needs and circumstances. Different services display different strengths and problem areas, these need to be identified and used as baseline information for agreeing priorities for action.

8.1.2 Services in each Strategic Health Authority (SHA) area need to work together, supported by the National Institute for Mental Health in England (NIMHE) Regional Development Centres, to undertake a joint acute care service mapping and ward profiling exercise so that the clear evidence base on which to make informed decisions is available. This work to be undertaken in conjunction with local NSF Local Implementation Team's service mapping and development work.

8.1.3 Each Acute Care Forum should undertake a service mapping exercise to identify in detail the baseline information required to know what is happening in our current inpatient services i.e. how the ward works and how staff and service users spend their time?

A profile should be developed for each Trust on allocation of resources, use and practice in each ward. The profile should include the evidence on

- Basic demographic information on inpatient service users.
- Availability and use of community treatment options.
- Use of MHA sections.
- Admissions and re-admissions.
- Lengths of stay.
- Availability, allocation and supervision of staff.
- Staff activity on the wards (observation, escorts, ward reviews, direct contact with service users).
- Consultant episodes.
- Service user involvement.
- Carer/family involvement.
- Features of ward/unit environment.
- Multi-disciplinary inputs.
- Activities available.
- Communication and co-ordination.
- Staffing including grading, qualifications and specific expertise.

8.1.4 Service mapping/ward profiling will facilitate making sound comparisons between local services and their counterparts to identify service deficits, good practice and scope for improvement. It will allow services to agree approaches to setting essential and deliverable standards in the context of the key themes of this guidance and of local and national good practice. It will assist service commissioners to make informed decisions on the nature and levels of service required.

8.2 Practice Development

8.2.1 In order to ensure service and practice deficits are tackled; that staff feel valued and supported and that good ideas are fully realised and exploited there needs to be a focus on practice development roles, forums and networks. Practice development roles and forums will be essential to deliver the changes required in the context of continuous improvement.

8.2.2 There need to be widespread development of leadership, practice and professional development posts in acute and inpatient care. Each service should have a nominated practice development lead who works

across disciplines and a lead consultant psychiatrist to champion the development of better acute inpatient services and facilitate the organisational and clinical practice development required.

8.3 Acute Care Service Improvement and Practice Development Networks

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 fort 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.

Virtuall

Virtuall is a new learning organisation combining 'e' based learning with practical development programmes for better mental health for London.

Its development network for inpatient services, launched in June 2001, is for frontline staff working in the wide variety of London's inpatient services, in hospitals and prisons. Service users and carers are also involved in the network. Through network days and its web site, Virtuall gives practitioners the opportunity for shared constructive reflection that will help them make a real difference in the way they work, influence pan-London and national policy.

In addition to the creation of local posts and local acute care forums there is a need to establish an external service and practice development infrastructure to organise benchmarking, support practice development and to link across services and take them forward.

8.3.1 A service improvement and practice development network must be established for each NIMHE Regional Development Centre/SHA. This network should:

- Commission and organise the service mapping/benchmarking exercise, identifying and reporting on areas of particular concern and priorities for action.
- Identify good practices and service innovation and promote practical development.
- Set standards and disseminate guidance.
- Consider the need for acute inpatient care provision as specialist services or enhanced skill areas to cover specific needs.
- Have clear links with higher education and professional development bodies to develop clinical, research and training initiatives, taking account of the specific education and training guidance to be issued later this year.

8.3.2 All acute inpatient services must through their local forum belong to their local network so that an agreed optimum model of practice that all services are signed up to is developed and monitored and supported.

8.4 Clinical Governance

8.4.1 NHS Trusts need through their clinical governance mechanisms to give greater attention to the nature and quality of local acute care service delivery both at the ward and system level.

Clinical governance needs to pay specific attention to the key themes of this guidance and to the priorities for change identified by the acute care forums and regional networks for service improvement and practice development.

8.5 Future Research and Evaluation Studies of Acute Inpatient Care

There is a dearth of mental health research studies relevant to inpatient care.

8.5.1 A review of the evidence that exists on the provision of existing inpatient mental health care has been undertaken which highlights the paucity of quality research in this area and the urgent need to commission research and evaluation on acute service effectiveness in the context of the NSF and NHS plan.

Recommendations

Integrating Inpatient Care Within A Whole System Approach

- Each Trust must establish an Acute Care Forum with firm links across the elements of the acute care system.
- Acute inpatient care must form part of a planned and integrated whole system, delivered in conjunction with the community mental components of the NSF system of care.

Services Need to

- Maximise their connections to community services and supports.
- Develop shared service user centred principles and processes and consistent operational policy across the care system.
- Develop effective joint working between inpatient care and crisis resolution/home treatment teams.

Care Pathway Arrangements

- Inpatient treatments specific purpose for and expectations of each service user must be addressed as part of their individual care plan.
- Integrated care pathway policy and documentation must be in place to improve joint working, care delivery and communication across the range of acute care services.

Admission and Reception

- Reception and admission arrangements must ensure that service users are made welcome, properly informed, orientated to the inpatient unit/ward environment, and have any immediate needs and concerns dealt with.

Structuring Inpatient Ward Arrangements

- There must be absolute commitment to and robust means in place to ensure service user and staff collaboration in the organisation on the inpatient ward.
- Ward arrangements must be organised and structured to maximise the time spent directly engaged with service users and carers.
- Multi-disciplinary input from the full range of care professionals must be prioritised to ensure adequate input to individual care plans and to the effective organisation of the ward as a whole.
- A flexible range of appropriate therapeutic and recreational resources and activities must be available.
- It is essential that staff have the opportunity to jointly reflect on the impact of the day to day work with users and their families in order to feel informed and empowered to make the most effective interventions.

Leadership

- There must be named clinical and professional leads with responsibility for ensuring the effective clinical inputs and co-ordination across the acute care system.
- There needs to be a specific focus on investment in the development of inpatient and acute care nursing leadership.
- Each inpatient ward must have a dedicated lead consultant psychiatrist.

Staffing

- The key competencies of inpatient mental health staff need to be more closely defined and incorporated into grading criteria and training packages.
- Opportunities to develop single management and staff team arrangements across acute care services need to be pursued.
- Staffing levels and skill mix must be sufficient and geared to the provision of high levels of engagement with service users.
- There must be a clear policy on the use of bank and agency staff.
- Effective staff support and supervision arrangements must be in place.
- Services should actively encourage recruitment of staff that accurately reflects their catchment area population.
- Commissioners of services must ensure inpatient wards are adequately staffed informed by Acute Care Forum and service development network benchmarking.

Education and Training

- Trusts must ensure that inpatient staff are educated and trained with the skills, knowledge and attitudes required in line with the specific education and training guidance produced in conjunction with this report.
- Adequate training time must be planned and programmed in the context of acute inpatient care delivery pressures.

The Ward Environment/Buildings

- The physical inpatient environment and domestic arrangements must be organised to deliver a comfortable, relaxed, safe and secure environment.
- Specific attention must be placed on ensuring the physical and psychological safety of women.
- Commissioners of new inpatient provision should seek to develop services in socially inclusive settings that reflect a positive vision of mental health.
- New acute care provision should be designed to maximise service and community connections.

Developing and Sustaining Improvement

- In each SHA area a service improvement and practice development network must be established.
- An acute care service mapping and ward profiling exercise must be undertaken.
- An acute care practice development lead must be designated for each provider Trust.
- Clinical governance arrangements need to prioritise monitoring the implementation of this guidance.
- Research and evaluation on acute inpatient services in the context of the NSF needs to be commissioned.

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NB. Further information and sources of information will be included on the web site of the National Institute for Mental Health in England being launched at the end of June 2002.

Appendix: Membership of National Inpatient Task Group

Mental Health Acute Inpatient Task Force was established to oversee the development of this guidance and to provide expert advice, ideas and to indicate good practice. The membership of this group is listed below.

In particular the following should be acknowledged for their contribution.

Malcolm Rae, Chair of the advisory group, Paul Rooney, author of this report, South Birmingham Mental Health NHS Trust and the members of the core group – Lis Jones, Dr Stephen Pereira, David Richards, Simon Rippon and Ingrid Steele.

The guidance while in draft has been considered in detail by representatives from all key settings and professions.

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32. Stephen Pereira.
33. Mike Preston.
34. Maria Quinn.
35. Malcolm Rae. (Chair)
36. David Richards.
37. Simon Rippon.
38. Paul Rooney.
39. Angie Russell.
40. Mike Smith.
41. Ingrid Steele.
42. Sandy Taylor.
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44. Margaret Worsley.

Also thanks to Donna Woodall from South Birmingham Mental Health NHS Trust for secretarial and administrative support to produce this guidance.

Produced by Department of Health
27765 1p 1k Apr 02 (RIC)
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