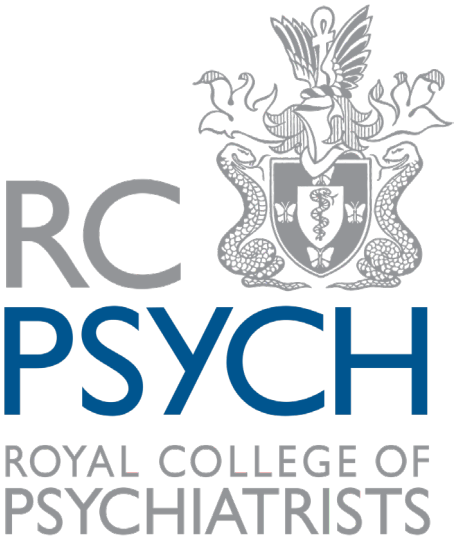

Response from the Royal College of Psychiatrists

Exploring mental health inpatient capacity

Response from the Royal College of Psychiatrists

Mental health services in the UK have been transformed in the space of a generation. While long-term institutional care used to be the norm for people with severe mental illness, admissions to inpatient mental health facilities are now comparatively rare. Despite many challenges and setbacks, this represents a huge advance in care and treatment to the benefits of countless individuals and their families.

But this is an incomplete revolution. The closure of the old hospitals was never backed by a corresponding investment in community mental health services, social care and vital infrastructure. This includes areas such as supported housing that can have a substantial positive impact on the lives of people with serious mental illness, and can be a lifeline for older adults, homeless people and people with intellectual disabilities. This has been exacerbated in recent years with the hollowing out of many local authority social services. Meanwhile there has been a continuous reduction in the number of inpatient mental health beds. As a result, too often the lived experience of patients in a mental health crisis is that an adult acute inpatient bed is not available when they need it.

We commissioned this analysis to support our ambition that a psychiatric bed is readily and locally available for anyone who is acutely ill and in need of inpatient care. It is unacceptable for anyone under these circumstances to experience a lengthy stay in the emergency department, to be sent away from their local area to receive the care they need, or to be admitted to a general and acute bed where there is a relative lack of dedicated mental health nursing and psychiatric expertise. It is also a matter of equality. It would never be deemed acceptable for someone requiring acute coronary care to be admitted to a psychiatric ward.

This is not a new problem. In 2016, the Commission to review the provision of acute inpatient psychiatric care for adults in England[a], chaired by Lord Crisp, set out the pressures on mental health beds and established a clear way forward through a quality improvement approach. Two of its foremost recommendations were for the practice of sending acutely ill patients long distances for

[a] The Commission also published a companion report for Northern Ireland, Building on Progress, in June 2016.

non-specialist treatment to be phased out by October 2017; and to support this, for local areas to undertake a service capacity assessment and improvement programme to ensure that they have an appropriate number of beds, as well as sufficient resources to meet the need for rapid access to high quality care.

The government subsequently set an ambition to eliminate inappropriate out of area placements in mental health services for adults in acute inpatient care in England by 2020/21. This has been coupled with an unprecedented focus on and investment in improving mental health services, from the Five Year Forward View for Mental Health to the NHS Long Term Plan. The latter includes plans to work with local areas with a long length of stay to bring this down to the national average of 32 days, as well as welcome commitments to improving community mental health treatment.

Three years on from the Crisp Commission, we have not seen sufficient action on its recommendation for local service capacity assessments to be undertaken. That is not to say that local areas are not doing their best to improve the care they provide to people in a mental health crisis. But what is clear from this report is that there is not sufficient capacity across the system to meet the level of need. It demonstrates that despite the positive work and commitments by NHS England, pressures on inpatient beds have not subsided.

The challenges to reduce the persistently high rates of inappropriate out of area placements and provide timely access to and discharge from acute inpatient services remain substantial. Mental health bed occupancy has risen in most areas above the 85% occupancy level recommended by the College and waiting lists for mental health beds have grown. It cannot be right that a patient in mental health crisis is in some circumstances more likely to be admitted to a general and acute ward than they are to a specialist inpatient ward.

The RCPsych believes that patients should get the right care when and where they need it. In the medium and long term that can only be sustainably delivered on the firm foundation of excellent community mental health and social services rather than simply increasing inpatient beds.

But we also need action now. As this report shows, services in many parts of England are dealing with a dangerously high pressure on beds resulting in poor patient and carer experience and less than optimal outcomes. Providers are forced to send patients many miles from home for care that is inappropriate to their needs and wastefully expensive.

The RCPsych is calling for additional funding for adequately staffed and resourced specialist mental health beds in priority areas to relieve the current unsustainable pressure they are facing.

This would create the breathing space that services in many regions need to get out of the beds trap and move forward with the ambitious vision for mental health services set out in the NHS Long Term Plan.

The Government's decision to invest a further 2.3 billion pounds a year in mental health services in real terms by 2023/24 through this plan – with a new emphasis on community services – provides us with an opportunity to move decisively towards parity for people with mental illness. We must ensure that services in all parts of England are able to grasp that opportunity.

Professor Wendy Burn
President, Royal College of Psychiatrists

RCPsych policy response – setting out a complex solution to a complex problem

There is no single solution to this complex issue and several important factors to consider. The declining trend in bed numbers has been a significant contributor to the challenge of meeting the 85% recommended bed occupancy rates.

However, bed occupancy is far from the only determinant, and a whole-service perspective is needed, including capacity in crisis teams and community mental health services, as well as a focus on supporting timely discharge of patients.

It is also important to acknowledge the interdependency across the system, such as where changes in the availability of appropriate alternatives to inpatient admission in the community setting will impact on bed occupancy rates in hospital, and vice versa.

Finally, there are limitations in the available data, including that bed occupancy is not broken down to specific types of mental health bed. For example, there is no routinely collected data on the number and use of specialist inpatient

substance misuse beds, yet we know that many of these specialist units have closed down.

The College believes that a blended and complementary approach is required in the short, medium and long term.

1. Immediate: additional mental health beds are required in priority areas

While this report found that an additional 1,060 inpatient beds would be required to meet the recommended rate of 85% bed occupancy across all STPs, we do not believe that the response should be the same in each area as bed shortages are unevenly distributed around England.

This analysis shows that there are priority areas where the pressures on the mental health system have reached unacceptable levels. While we know that these areas are actively working to address these challenges, we believe immediate action is required. Of particular concern are those STP areas with consistently high rates of inappropriate out of area placements.

As this report shows, the following areas have the highest level of inappropriate out of area placement over the past two years (often having three or more new placements per month per 100,000 population weighted for mental health need):

- Bristol, North Somerset and South Gloucestershire
- Devon
- Hampshire and the Isle of Wight
- Lancashire and South Cumbria
- Lincolnshire
- Norfolk and Waveney
- Nottinghamshire.

We believe these areas should be investing in additional inpatient bed capacity to ensure a local bed is available for all patients who have been sent inappropriately out of area. As these additional local beds become available, and the number of inappropriate out of area placements declines, there should be a phased diversion of resources from the latter to cover the ongoing costs of the additional local beds.

As this report also demonstrates, inappropriate out of area placements are not the only adverse consequence of high bed occupancy.

It also reduces the time for comprehensive discharge planning, puts an unrelenting pressure on staff and increases the risk of violent incidents on units.

The College therefore believes that those areas without high rates of inappropriate out of area placements but with persistent 95% plus bed occupancy should also consider investing in additional local psychiatric beds as a part of their transformation plans to deliver the NHS Long Term Plan. This includes the following STP areas (often with bed occupancy over 95% in the last two years):

- Birmingham and Solihull
- Cornwall
- Mid and South Essex
- North Central London
- South East London
- Sussex and East Surrey.

It is vital that the introduction of these additional beds is aligned with local service delivery and mental health workforce planning to ensure they are properly staffed and resourced. Consideration of the physical estate for these new beds is also needed to ensure they provide a safe therapeutic environment.

2. Over the next 2 years: maximise the therapeutic value of inpatient stays and undertake a local service capacity assessment

Inpatient services are the most expensive and constrained component of the mental health system. And yet there appears to be little consistency in the way different health economies use these services. There is considerable variation in need-adjusted bed numbers, admission rates and average length of stay and no agreed clinical criteria for admission or discharge. As much as 10% of all mental health beds are occupied by patients who are well enough to go home.

Average lengths of stay in general hospitals have fallen considerably over the past 20 years. Similar reductions have not been seen in mental health services.

We call for a national programme to support mental health providers to ensure that every day that a patient spends in hospital is a day well spent, with clear clinical objectives. Initiatives such as the Red2Green campaign provide some indication of what is required. We must be clear why a patient has been admitted and when a patient is well enough to be discharged.

Reaching a clinical consensus on these issues, codifying the results and introducing mechanisms to assess patients daily will not be straightforward. But it is clear that any proposed solution to the problem of high bed occupancy which does not consider how those beds are used, will be incomplete.

We also reiterate our support for the recommendation in the Crisp Commission for local areas (at STP/ICS level) to undertake and publish a service capacity assessment and improvement programme if they have not already done so. This should adopt a quality improvement approach to:

- Establish the base line for demand, identifying peaks and troughs, and introduce processes for continual measurement of demand and capacity
- Provide robust data on the number and use of inpatient beds, broken down by type of mental health bed
- Introduce interventions designed to reduce demand or increase capacity (e.g. strengthening crisis teams, adding more beds on a temporary or permanent basis, auditing whether the care received by patients is concordant with NICE guidelines, improving bed management or reducing delayed discharges)
- Study the result of the individual interventions, ensuring that the adverse effects of any interventions are captured in the measurement system
- Make adjustments as necessary
- Embed effective interventions into standard work and normal practice.

3. Over the next 2 to 5 years: invest in high quality community mental health services

Whilst investing in additional beds in priority areas, and assessing and maximising the value of inpatient services, are important, our members are clear that the long-term focus should be to increase the capacity and capability of community mental health services.

This was the primary conclusion of the 2016 Crisp review, and it remains a core action area. For example, ensuring there are appropriate community services to support older adults and those needing rehabilitation support when they are ready to be discharged will substantially improve their quality of life.In line with the NHS Long Term Plan, its mental health implementation plan and the new Community Mental Health Framework for Adults and Older Adults, all STPs and ICSs must engage stakeholders to develop a consensus on how to strengthen primary and community services to move demand away from inpatient beds and into community settings.

In some areas these discussions will already be well-progressed, in other areas these discussions must be initiated as a matter of urgency to ensure the benefits of the new funding coming through the NHS Long Term Plan are realised.

This planning must lead to quantified plans for service development and service delivery which are widely understood and supported by staff and patient groups.

The plans must set out the STP/ICS's forecasts for the numbers of people with mental illness by diagnostic group; the referrals, caseload, throughput and staffing levels of each of its community team types (e.g. early intervention, CMHT, crisis resolution etc); the numbers of inpatient beds and staff, and the rate of admission to and occupancy of these beds.

The plans should include clear milestones so that actions can be tracked, and progress can be evidenced.

They will also need to reflect the changing profile of community service referrals and the associated pressure on staff where community teams are increasingly now assessing and treating patients that previously would have be treated in an inpatient setting.

Uncertainty is inherent in long-term service planning. But this report highlights that planning uncertainty is exacerbated by the paucity of evidence relating to community interventions which reduce demand on mental health beds.

We call on researchers and academic institutions to address these gaps and thereby reduce planning uncertainties. In the meantime, STP/ICSs should also make clear their assumptions about the extent to which future investment in community service provision will offset the need for mental health beds.

NHS England and healthcare regulators should assure themselves that STP/ICS plans are robust, underpinned by extensive stakeholder discussions and sound analysis, and that implementation arrangements are adequately resourced.

The Royal College of Psychiatrists will work with stakeholders to support action in these areas and will use its monitoring tool, Mental Health Watch, to track progress and highlight the areas that are succeeding in reducing pressures on in-patient beds and those that are not.

Contact:

Tel: 020 7235 2351
Address: 21 Prescot St, Whitechapel, London E1 8BB