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Acute wards: problems and solutions

Their fall and rise

This paper will outline some of the long-standing problems and new challenges facing acute in-patient care, some of the recommendations for change and various difficulties encountered in trying to improve the situation. It will describe how a collaborative approach (led by the Northern Centre for Mental Health, the Centre for Best Practice in Leicester and both the Northern and Yorkshire and the Trent regional offices) can bring about tangible and measurable change for the better and what lessons there may be for the management and delivery of mental health care in the future.

Problems

For many years, national mental health policy has focused on community care and a great deal of energy, training, education and resource allocation has been used in trying to make it work. There have been notable successes and few who work in or use mental health services would argue against the direction in which things are moving. However, there have been a number of consequences that could, and should, have been foreseen but which have, until recently, received scant attention. These have included the inevitable change in case mix on acute in-patient wards and the skills and resources needed to ensure that these units are able to play a full and proper part in an integrated mental health system (Department of Health, 1999*a*).

As a result, major problems are now widely reported with the provision of acute in-patient care, with unacceptably high bed-occupancy levels (Greengross *et al*, 2000), pressure on staff (who are often insufficient in number and lacking in the requisite breadth of skills) and a system of treatment and care that fails to meet patients' needs and expectations (The Sainsbury Centre for Mental Health, 1998). Given that in-patient units consume a large proportion of the mental health budget, these circumstances are obviously less than ideal, especially when the purpose of many admissions seems to be unclear beyond a perceived lack of alternatives to manage risk.

Surmounting these issues is a wide range of new challenges facing adult mental health services included in the National Service Framework (Department of Health, 1999*b*) and the NHS Plan (Department of Health, 2000); at the very least we should be providing environments in which people feel safe, where their dignity and privacy are respected and within which individuals' specific needs can be met. These may relate to specific clinical issues or, indeed, be as basic as the need for single-gender accommodation and cultural sensitivity. The obvious question is, how are in-patient services to meet these challenges when so many appear (on the face of it) to be in such a parlous state?

Solutions

The answer is that things are probably not as bad as they seem at first glance. Disinvestment and disinterest have left some feeling bruised and beleaguered, but against this apparently bleak backdrop, examples of good practice (such as the Tidal Model of nursing) can be found in a number of places. To put it another way, many of the solutions are out there, developed by front-line mental health staff whose creativity, dedication and determination have enabled them to make some extraordinary changes.

It is important first to point out that there are a great many ideas and recommendations for significant improvements, which are easily available and generally well known (The Royal College of Psychiatrists, 1998; The Sainsbury Centre for Mental Health, 1998). Such eminently sensible suggestions make it easier for us to think of potentially ideal models (for example, small, locally based, specialist units, with a narrow case mix) but this frequently presents us with daunting logistical problems and large resource implications. The danger is paralysis; we know where we want to be but the journey seems too long and arduous to know how to start. Obviously, it is vital that we pursue notions of aspirational ideals that should represent our benchmarks, but we need ways of improving what we have got in the meantime, here and now.

We know that good advice is not enough; in spite of the amount of information available, services and practice are slow to change and, although there is undoubtedly a

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need for more resources, increased spending is not the only answer and neither should it be a prerequisite for attempting to make things better. In 1991, the Institute for Health Care Improvement in Boston began attempts to accelerate improvement in health systems throughout the US, Canada and Europe. It has done this by systematically facilitating collaboration among health care organisations on a scale that was previously unknown outside the research community. Over the years, a number of 'breakthrough series collaboratives' have been developed across different health fields and have yielded some impressive results in the short- to medium-term.

The mental health collaborative

In order to address the problems in acute in-patient care (which are now, thankfully, a priority for mental health service managers) and overcome the usual obstacles to change, the Institute of Health Care's methodology was adapted to run a 'mental health collaborative' across all mental health teams in the Northern and Yorkshire and Trent regions. In this country, collaboratives have been run in orthopaedics and cancer care and, indeed, others are being established, but this was the first such mental health project.

The project was jointly commissioned by both of the regional offices and effectively began in May 2000 by convening a reference group. This was a multi-disciplinary group of people from across the regions (including input from users and their representatives) who had a particular interest in acute in-patient care. They met for a full day to generate ideas for change, around which improvement measures could be developed. In total, 24 such standards were agreed, together with targets for achievement covering the processes of admission, stay and discharge, and these were incorporated into the Collaborative Project Manual. The key areas for improvement agreed by the group were:

(a) Undertaking pre-admission expert assessments (the purpose of this is obvious and we agreed our own definition of 'expert assessment').
(b) Ensuring clarity around purpose of admission (it was agreed that reasons for admission are too often unclear and different people within the system – including the patients – may have entirely different notions of these).
(c) Developing effective communication (as mental health professionals we like to think we are good at communication; service users told us otherwise and pointed out that, in hospital, we tend to communicate with them at times and in ways that suit us, not them).
(d) Ensuring patients are centrally involved in their care planning.
(e) Ensuring the availability of appropriate therapeutic options (it really does not seem sensible that a comprehensive range of psychological and social interventions may be available in the community in many services, but in hospital, when people are most ill and vulnerable, such interventions are nowhere to be found).
(f) Ensuring that there is effective multi-disciplinary teamworking.
(g) Undertaking effective care planning for discharge and prompt follow-up.

None of these ideas should seem particularly controversial or complicated, but with specific targets for improvement established, the intention was to ensure they were achieved. With these agreed, the next project milestone was an initiation day held in October 2000; 37 multi-disciplinary clinical teams attended and discussed the reasons for the project, its aims and the collaborative process. The proposal was that all teams should collect baseline data around the improvement measures and work collaboratively, sharing the good ideas that clinicians often have, to achieve the targets. Support was given in the form of time from a local project manager, facilitated electronic communication between participants and four specific learning sessions over the course of a year. These were two day-events that were attended by all teams. They incorporated a blend of keynote talks, workshop sessions and opportunities to share progress and practice. The first was in January 2001 and the last in November. The first tranche of data on the improvement measures collected after 3 months was extremely encouraging and there were many examples of imaginative solutions to practical problems. In addition to our own data collection, an external evaluation of the project was undertaken by the Health Services Management Centre from Birmingham University.

The early promise shown in the first quarter of the project was sustained throughout; by the final data collection in December 2001, 377 permanent changes had been made, the overall percentage of targets being reached increased from 19–49% and there was a steady and sustained positive trend in the number of improvement measures achieved across all teams. Even when improvement targets were not fully achieved, there was evidence that many teams significantly improved upon initial scores during the year, indicating a better quality of care.

As the methodology for achieving change has led to significant improvements in acute in-patient care in mental health services across two regions, some fundamental issues need to be addressed. The first is around the sustainability of change; with the project formally finishing in December 2001, there is a need to embed not only improvements but also, crucially, the process itself into everyday practice to ensure a continuous cycle and culture of review and development. Doing this will require ongoing support of trust chief executives and their boards so that organisations find ways of ensuring that collaborative practice is the norm. The second issue is about spreading change; how can others learn from the changes being made in our two regions? Even more fundamentally, if this methodology genuinely leads to significant, achievable and sustainable improvement faster than anything else, then it should be implemented by everyone.

Central to the process has been the fact that teams systematically collect and receive useful information and are empowered to ask questions and seek solutions to a

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much greater extent than they have been before. Among other things, this has led to a much more substantial engagement of service users in monitoring and designing the services they receive. Perhaps all of these benefits have come about because the improvement measures reflect clinical priorities and user experience; the result appears to be that teams will work hard to try to achieve progress towards their targets. It could be argued that there are lessons in this for the way the NHS develops performance indicators.

Conclusion

The problems facing many acute wards may seem utterly daunting, but there really does seem to be something in a systematic collaborative approach that can lead to rapid and significant improvements. It requires planning, enthusiasm and commitment, I know the solutions are out there, because I have seen them.

Declaration of interest

None.

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Clinical governance in the asylum

Clinical governance was introduced in 1998: 'a framework through which NHS organisations are accountable for constantly improving the quality of services and safeguarding standards of care by creating an environment in which excellence in clinical care can flourish'. (Department of Health, 1997)

The closure of Bexley Hospital, a Victorian asylum, in 2001 led to the rediscovery of the formal minutes of the Medical Staffing Committee, 1949–1961. This period of enormous political and social change and scientific advances encompassed the early development of the NHS, the introduction of imipramine and chlorpromazine, the 1959 Mental Health Act and the development of multi-disciplinary working and community care. This gave a unique opportunity to explore how new a concept clinical governance is. The minutes were examined for material relevant to some of the main components of clinical governance outlined in the NHS White Paper, *The New NHS. Modern, Dependable* (Department of Health, 1997). As we are so often reminded in the assessment of clinical risk, the best predictor of future behaviour is past behaviour.

Risk

> 'Clinical risk systematically assessed with programmes in place to reduce risk.' (Department of Health, 1997)

Issues of clinical risk clearly preoccupied the Committee, although violence and suicide did not receive a single mention; perhaps they were regarded as inevitable. What did matter was containing devastating outbreaks of dysentery and the spread of tuberculosis, obtaining supplies of fresh blood for transfusion at weekends and persuading local physicians and surgeons to make their expertise available. There are numerous references to outdated and inadequate equipment and the ongoing struggle to retain a functioning operating theatre.

The health risks associated with falls were acknowledged and it was suggested that 'as a start, non-skid floor polish should be experimented with in infirmary wards'. Clinical governance requires that professionals act only within the bounds of their competence and psychiatrists faced a dilemma about how much physical care they should provide. When the local radiologist insisted that all patients referred for a barium enema should undergo a sigmoidoscopy by their psychiatrist, most, but not all, refused to cooperate.

Evidence-based medicine

> 'Evidence based practice is supported and applied routinely in everyday clinical practice.' (Department of Health, 1997)

Following lengthy discussions about the relative merits of many mixtures with similar compositions, a hospital formulary was finally agreed. The names of the mixtures tended to describe their purpose rather than their constituents, with each consultant having his/her own preferred concoctions. For example, Mist Comerfordii, a mixture of chloral and various bromides, was named after Dr Comerford, the chair of the Formulary

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