Raising the Standards in Systems of Acute Care
Presentation Notes Nick Adams

The issues covered below are addressed in the Systemic Management Tool that accompanies this presentation, that tool can be used as a local audit tool to help determine action points for Acute Care Mangers and Acute Care Forum.

If we use pathways of care to describe teams and wards that collectively make up any Trusts capacity for Acute Care provision, it is clear that a non-integrated approach leads to teams and wards working in isolation. This is obstructive to communications, working relationships and systemic management and it certainly leads to “broken” or dis-integrated pathways of care for pope entering and using mental health services.

The development of new approaches to Acute care, such as Crisis Resolution / Home Care teams, can not be reasonably expected to improve care pathways, or improve the effective use of local capacity if they are not developed as integrated parts of a system of care. In short, the development of Crisis Resolution / Home Treatment, or any other service in isolation will not solve many of the complex issues involved in the management of Acute Care Services. A systemic approach to development and management is essential to effective use of resources and to effective pathways of care for clients.

Whilst CR/HT should be the preferred pathway in to Acute In-patient Care, it also enables wards to facilitate planned discharge, very often earlier than could have otherwise been possible. This is not to be mis-interpreted as a justification for discharge from an acute level of care without the need for planned support of community teams such as CMHT or Assertive Outreach, indeed some clients may well be discharged from In-patient care back to a CMHT or AOT.

Is there a bed management strategy, which must include:·
A person / people with a dedicated bed management role,·
A policy agreed by all acute services (Acute In-patients, ICU, Acute Day Services and Home Treatment)·
A policy agreed with neighboring Trusts on access and planning the return of patients to acute beds in their own areas ASAP.·

What is being done about managing the capacity of your Acute Services?
Can you provide and analyse data to prioritise areas of potential risk These areas of risk would include:·
Clients being discharged from Acute In-patient care to their own home,
Discharge planning, ·
Transitions of care, ·
Levels of need against staff numbers and competency.

Can you provide and analyse data to prioritise areas of potential saving. These areas of potential savings may include:·

Patients waiting to go on to less intense residential care, ·
Reduction of inappropriate admissions by improved liaison and triage roles such as via Accident and Emergency, Police out of hours GP's.
Are CR/HT Teams, other community teams and Acute Day Services aware of patients awaiting discharge that they should be planning for as a part of their overall case management?

Is there weekly performance management of the following points?·
Actual reasons for admission·
Use of MHA sections·
Lengths of stay·
Reasons for "bed blockages".·
Discharge plans and provisional discharge dates being set·
Patients being discharged with an up to date relapse plan·
Patients followed up 7 days after discharge·
The use of observation and agreed observation levels·
The use of the Intensive Care Unit·
Previous admissions and reasons for readmission·
Care plans set in partnership with clients and where permission is given with the family member / carer

How does your overall service development effect Acute Care provision? For example…·
What are your local development plans regarding Crisis Resolution / Home Treatment?·
To what extent do these plans incorporate Acute In-patient Units and Acute day care Services?·
Do your operational policies relate to each other as a system or are they isolated? This means - do you ensure that teams and wards co-ordinate and work together as a system with robust ways of planning care pathways (including admissions, leave periods and discharges) or do they work in isolation from each other?·
What impact has your Assertive Outreach team had upon acute Care Services?·
To what extent has liaison between CMHT's, CR/HT Team and GP's affected the appropriateness of admissions into In-patient Units?Are your consultants regular members of the community teams to the extent that there are team decisions on case reviews, allocations, discharge plans etc that integrate out-patient department and CMHT's?

Do the Acute In-patient Units get frequent in-reach from community mental health services including..?·
CMHT's ·
Assertive Outreach Team·
Crisis Resolution / Home Treatment Team.·
Acute Day Services·
Specialist disciplines such as Psychology and Occupational Therapy that may not be ward based.

How well is Community Care monitored following discharge?·

Do Community Care Co-ordinators attend ward based reviews of clients in the In-patient unit / ICU?·
Do you have a risk management policy that requires that all care plans have a clear and relevant risk assessment and management plan that is provided to all of the people involved providing in each patients care?·
To what extent are patients being followed up within 7 days of discharge?·
What is the rate of 30-day readmission in relation to comparable areas?·
When did your trust complete its last audit of CPA in line with the DoH Guidance?
What were the local findings and what have you done to act upon those findings in order to implement recommendations of "Effective Care Co-ordination in Mental Health Services?
Are your local CPA audit and related actions co-ordinated through your clinical Governance Programme?

How well do people understand the role of Acute Services?·
How clear, or clinically "SMART", are the treatment objectives of people receiving In-patient Care?·
Are there admission criteria, if so what are they?·
Is there a referral protocol for admission from all community teams that outlines the need for clear treatment objectives, arrangements for transition of care, discharge planning?
Do all patients have care plans?

In what ways is the In-patient workforce being managed and developed?·
What is the current level of vacancies for ward based staff, what is being done to develop a solution if a shortfall is identified?· Are sickness absence rates a problem, if so what is being done to find a solution?·
Is overtime monitored in hospital, if so give details including any current policy, frequency, number of hours overtime a nurse can work, areas of deployment, correlation to sickness rates and service demands e.g. high observation levels.·
Are overtime levels high in relation to comparable areas, if so what is being done to find a solution?·
Are there adequate numbers of trained and untrained staff on the bank?·
Is clinical supervision fully provided, if so please give details, if not what is being done to provide a solution?·
What is the level and frequency of doctors' appraisals?·
Do doctors' practices reflect working in a modern mental health system as described in NSF Policy Guidance?
Are consultant admissions reviewed, if so how often and by whom?
What have been the admission trends or changes in the past 12 months?

What are the current membership and agenda points of the Acute Care Forum?·
Has it reported to the Board?·
Is there a lead Operational and Medical Director?·
Is the Regional Development Center facilitating any meetings / agenda items?·

Does the forum have an action plan addressing any of the pressures outlined in these questions?
Does the Forum have any additional agenda points and action plans, if so what are they?

To what extent does the PCT work with providers to understand and manage the pressures upon services?·
To what extent are mid – long term residential care providers reviewed as to the provision of discharge pathways from Acute Services?· What has been the role of the LIT and PCT's in formulating local development plans and proposals that affect acute mental health services?· What are the LIT and PCT's able to do to support providers with developing locally agreed plans, such as providing statistical and financial analyses, public consultation, facilitating discussion with other relevant service providers in statutory and non-statutory sectors?· Are there joint discussions with the Strategic Health Authority MH Lead? ·
How does your area compare with other in terms of population needs and levels and types of service investment, per capita? Can you make these comparisons with other areas in your StHA areas and nationally with other areas have similar population profile?·
How do the PCT work towards a joint commissioning strategy with Local Authority, non-statutory and private providers to address issues within a wider health ecomomy?

Does the Local Implementation Team include a representative of local housing / accommodation agencies such as landlords, Housing Associations and Supporting People in order to address some of the accommodation issues that can compound "bed-blocking"?

This presentation is accompanied by a number of resources developed as a draft CDROM for your support and guidance, however, resources that you are encouraged to involve in the development of your Acute Services are:
•Your own Acute Care Forum
•Nick Adams, Acute Care Lead, NIMHE West Midlands
•Kevin Heffernan, Community Teams Lead, NIMHE West Midlands

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