The Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults in England, Wales and Northern Ireland

Call for evidence
The Commission to review the provision of inpatient psychiatric care for adults in England, Wales and Northern Ireland

Call for Evidence

The Commission

The Commission to review the provision of inpatient psychiatric care for adults in England, Wales and Northern Ireland has been set-up in response to concerns about whether there are sufficient acute inpatient psychiatric beds and alternatives to admission available for patients and service users.

The Commission met for the first time in January 2015, and will be spending the next year gathering evidence and considering care in England, Wales, and Northern Ireland (Scotland is not included, as a separate programme of work is currently being undertaken by other organisations on the same issue). The Commission will produce its final recommendations in January 2016.

More information about the Commission can be found at www.CAAPC.info. The Commission receives administrative support from the Royal College of Psychiatrists, but has agreed its own terms of reference and will operate independently.

Our Call for Evidence

The Commission is beginning its work by asking all individuals and organisations in England, Wales, and Northern Ireland with relevant knowledge and experience for their help by completing this consultation. This includes all:

- Patients/service users
- carers and family members
- members of staff in mental health services (NHS, independent, or voluntary)
- providers of mental health services (NHS, independent, or voluntary)
- commissioners or planners of mental health services
- individuals and organisations involved in health or social care outside of mental health
- primary and secondary care staff (clinical and managerial)
- charities or voluntary sector organisations with an interest in this area
- individuals or organisations working in the criminal justice system
- Local Authority Bodies and individuals working for them
- Other relevant bodies or groups

Responses will be used to inform the Commission’s areas of inquiry and final recommendations.
What this consultation covers

In this consultation, we use the terms

- “mental health inpatient care” to describe:
  
  “a unit with beds that provides 24-hour nursing care, and which can provide care for patients detained under the Mental Health Act. Such inpatient units can be provided by the NHS or by other providers.”

- “alternatives to inpatient care” to describe:
  
  “alternatives to admission into an inpatient unit. This can include Crisis Resolution and Home Treatment Teams, Crisis Houses, Acute Day Services and other services.”

What this consultation does not cover

The consultation does not cover (a) services for children or adolescents or (b) services for people with dementia.

The consultation does not cover specialist inpatient services, unless the evidence directly relates to the provision of mental health inpatient care/alternatives to inpatient care. An example of this would be an issue relating to the transfer of care between specialist inpatient services and non-specialist inpatient services.

Specialist inpatient services are commissioned/provided at the national rather than local level. They include, for example, mother and baby beds, forensic inpatient services, and eating disorder beds.
Questions

Q1.
In your opinion, what is the **value** and **purpose** of inpatient mental health care for adults?

We are interested in hearing your views on the importance, worth, or usefulness of inpatient care. Please explain your answer (word limit 500 words).

There are a number of interconnected elements that constitute the value and purpose of inpatient care. Fundamentally, our member mental health service providers concur that it is desirable for the majority of mental health care to be delivered in the community because it can result in:

- a greater level of ‘normalcy’ and less disruption for service users/patients;
- improved and more frequent access to multidisciplinary care professionals;
- greater self-management and family/carer involvement in care and treatment;
- improved resilience and reduced readmissions;
- an improved service user experience of and satisfaction with care;
- better use of scarce inpatient resources for the most necessary admissions; and
- overall better care and treatment outcomes for service users/patients.

Significant evidence-based improvements in the quality and provision of in-community care and greater levels of pathways-focused cooperation amongst mental health, social care, acute service and local authorities mean that more patients can be treated at-home.

However, our members maintain that, although often seen as a measure of last-resort, inpatient care can often be a vital component in the patient’s journey to recovery and **there will always be a need for timely access to high quality, inpatient care**. It is particularly appropriate for patients/service users when:

- they pose a significant physical risk to themselves or to others during a period of crisis or on a longer-term basis;
- there are risks to the patient’s mental and physical health if they remain in a chaotic community environment or exposed to sources of their mental health crisis;
- the patient lacks capacity and insight and may not cooperate with their treatment plans without direct, specialist supervision;
- there is a high level of carer burden or strain that can be alleviated by a brief inpatient stay, assisting through a period of respite the normalisation of the carer’s coping mechanisms and facilities.

To be truly patient-centred and effective, it is critical that inpatient care balances the factors set out below:

**Safeguarding safety and managing risk**
- maintain the safety first and foremost of service users, then their families and the general public and others during a crisis period;
bring safety and containment to severely ill individuals, minimising the distress of acute mental health issues; and
provides an environment where contained and safe specialist intensive treatment can be received.

A supportive, recovery-oriented culture of diagnosis, assessment and treatment
early evaluation to arrive at a clear formulation and diagnosis, which is crucial for planning on-going treatment and follow up in the community;
a comprehensive assessment and treatment and options to enable safe discharge back in the community at the shortest time;
intensive treatment and supervision to higher risk patients presenting with an acute mental illness who cannot otherwise be treated in the community due to risk issues, vulnerability, adverse social circumstances;
gives patients confidence that they will receive appropriate and therapeutic care in a setting that offers them opportunities to make a meaningful recovery back to the community.

Respect and dignity for patients and their families
It is critical that inpatient care is conducted in a manner which is respectful to all and which values humans’ diversity and minimises distress experienced in moments of mental health crisis by the patients, their families and the wider community.

Our members advise us that there are many factors that help or hinder good quality inpatient care. We discuss these in our responses to the following questions. These are also made clear through the case study examples from our members that we have provided at Annex A.

Q2.
Please can you provide an example of:

‘good’ inpatient care
‘good’ alternatives to inpatient care?

Please explain your answer, and give as much detail as possible about what made the care ‘good’. Please also tell us where and when this example is from (e.g. Manchester, 2012).

Good inpatient care
Our members’ responses showed strong consensus that good inpatient care is most likely to occur where there is strong organisational leadership, clarity and shared understanding of the purpose of the inpatient unit that is supported through appropriate policy and operational procedures, with access to sufficient resources including beds and staff numbers of the correct skill mix. Specific aspects of good inpatient care that were repeatedly mentioned by our members include:
A clear purpose and process of inpatient admission that is service-user oriented and recovery-focused

- Clear entry, transfer and discharge criteria for inpatient care;
- Clear assessment protocols, risk assessments and standardised measures;
- Identifying goals for service user recovery that form the basis of a care plan that would demonstrate that the purpose of admission has been achieved and facilitate transition to community services with coping strategies to assist prevention of future mental health crises.

Conceptualisation of inpatient care as part of a pathway of care

- The role of inpatient care as part of a pathway of care that moves seamlessly from Community mental health team, home treatment to inpatient care ensures that an inpatient stay is only utilised when absolutely necessary and that communication between services and the patient is rapid and comprehensive.
- Such an approach ensures that service providers can identify blocks or difficulties along the pathway and identify where any deficits in information gathering have originated.

Establishment of a ‘therapeutic alliance’ with the service user as an expert in own care

Engaging the service user actively in the planning and management of their inpatient care and recovery plan can be achieved more effectively through therapeutic alliance-forming strategies such as:

- early orientation to the ward routine (including likely review schedules) and the identification and introductions of staff;
- open and honest communication about timescales and rationales for treatment;
- ensuring appropriate values are discussed and demonstrated;
- providing observation in a therapeutic and meaningful way and ensuring activities are available;
- seeking service user involvement and feedback about ward procedure;
- where appropriate, involving family and carers

Multidisciplinary teams that deliver early identification of service user needs

At early admission, a multi-disciplinary team that includes the patient will discuss and develop treatment and assessment interventions, monitor progress towards meeting the purpose of admission and develop coordinated discharge support with at-home and community care partners. Multidisciplinary input on wards achieves better outcomes and a reduced length of stay.

For example, St Georges Hospital NHS Trust considers inpatient units to function best in a functionalised model of care. This means that there is an inpatient team responsible for looking after patients during their inpatient stay, including the Consultant Psychiatrist who becomes an integral part of the team, along with Occupational Therapists, Psychologists, Pharmacists and Social Worker as part of that team.

Well trained and supported staff

- Appropriate skilled and trained staff;
- Adequate staffing levels and skill mix;
- peer support working
• Ensuring that issues of conflict and containment, which can arise when providing a controlled safe environment, are planned for and reflect the evidence base of the ‘Safe Wards’ research (http://www.safewards.net/managers/evidence).

Additional factors include

• Timely assessment and treatment interventions reflecting the latest available evidence that matches the intended purpose of admission; one to one engagement; joint care plans.
• A high standard of inpatient care facilities that are ‘fit for purpose’ can have a significant positive impact on the safety and therapeutic benefit of the physical environment.
• Finally, it is clear that the availability and quality of at-home and community care has a direct impact on the quality of inpatient care, as discussed in the next section.

Good alternatives to inpatient care

Our members have provided us with many specific examples of high quality alternative services to inpatient care and we have included these for the Commission’s reference at Annex A. Thematically, there was strong consensus that the use of Crisis Resolution Home Treatment Teams, when appropriate, offers advantages over inpatient care such as:
• a less restrictive method of intervention;
• promotes normalcy with less impact on personal lives of service users;
• service users report a more positive patient experience;
• greater enablement of Service User involvement in care;
• can provide care and treatment in the service user’s own homes and remain involved until the crisis is resolved;
• offer several visits a day, as required, administering medication to promote concordance and reduce the risk of self-harm/suicide;
• provide direct support to carers who are involved in service user care; and
• can arrange alternative accommodation if this is required into a crisis bed as an alternative to hospital admission.

Members consistently indicated that to be effective, Crisis Resolution Home Treatment Teams (CRHTT) and inpatient wards should be well integrated in order to:
• undertake joint risk assessments and clinical reviews of inpatients by senior CRHTT and inpatient medical staff to deliver more seamless care;
• help earlier discharge and prevent stagnation of patients who are admitted to hospital;
• ensure scarce facilities for inpatient care remain available for the most ill patients.

For example, Dudley and Walsall Mental Health Partnership NHS Trust told us their adult psychiatric treatment services were highly successful because:

“Each has a clear understanding of the other service and the patient’s journey of recovery is continued using a Wellness Recovery Action Plan (WRAP). Good communication between the [two] is imperative and
the pathways in and out of service are clear and known to all staff involved... Both teams are trained in the recovery model and one member of staff is employed in a joint funded role therefore ensuring strong links between the [two] services and consistency in approach for patients. This ensures a smooth journey through the services for the patient with clear objectives set to aid the journey of recovery. Both of the above services also have strong links, clear pathways and good communication with other services all of which are provided out of hours, namely the Crisis Service, the Urgent care service, the Psychiatric Liaison Service and the Street Triage Service. These services provide a “screening out” service prior to admission to either the inpatient or home treatment services ensuring that all other possible least restrictive options have been explored first thereby reducing the number of admissions to these services. Strong leadership and clear direction is essential to the success of both of these services.”

The case studies provided as examples at Annex A further illustrate why these different types of services cannot be planned and delivered effectively in isolation.

Q3. Giving as much detail as possible, please can you:

• provide an example of ‘poor’ inpatient care
• explain how that poor inpatient care could be improved?

Please explain your answer, and give as much detail as possible about what made the care ‘poor’. Please also tell us where and when this example is from (e.g. Cardiff, 2014).

Q4. Giving as much detail as possible, please can you:

• provide an example of a ‘poor’ alternative to inpatient care
• explain how that poor alternative to inpatient care could be improved?

Please explain your answer, and give as much detail as possible about what made the care ‘poor’. Please also tell us where and when this example is from (e.g. Belfast, 2013).

Poor inpatient care and alternatives to inpatient care

Our members advised us that the contributory factors to poorer patient outcomes can be identified in both poor inpatient and alternatives to inpatient care. Often complex and interdependent issues, thematically they include:

Weak leadership and lack of clarity of purpose, which results in:
• poor clinical leadership and a lack of focus on recovery and outcomes
• Poor teamwork and disjointed working across teams, Lack of continuity of care
• Disengagement of staff and poor staff morale
• Increases in non-commissioned admissions and readmissions
• Excessive risk aversion leading to inappropriate admissions and inappropriate use of beds
• Poor communication between inpatient/CHRTT teams and partner agencies
• Insufficient involvement of patients, carers and families in meaningful care planning
• Lack of early discharge planning and unnecessarily longer stays
• Poor identification of practical barriers to discharge such as housing and availability of community care.

Lack of standardisation in protocols and practices:
• Lack of national research and guidelines into therapeutic observations leading to inconsistency in treatment approaches
• Poor implementation of action plans and monitoring of outcomes
devolution and proliferation of poor practice in care
• Poor management of risks
• Insufficient legal safeguards and responses to protect staff and fellow patients from service user violence

Staffing issues:
• Inadequately skilled staff in inpatient and community settings
• Difficulties in recruiting staff to work in less desirable locations
• High staff turnover, sickness and absenteeism leads to higher use of temporary (bank and agency) staff reducing continuity of care and focus on recovery

Budgetary and resource constraints:
• Insufficient resources to improve poor quality facilities and care activities mean a less therapeutic environment for patients
• Insufficient resources to ensure adequate staffing levels placing excess demand and strain on available staff
• Increased risk of safety hazards and safe ward environment
• Poor quality IT and administrative systems
• Lack of 7-day working and 24/7 support means service users may be admitted to hospital and continuity of care is disrupted.

Poorly planned and under-commissioning of beds is leading to capacity issues:
• Unavailability of appropriate types of inpatient facilities
• Increased out of area placements
• Delayed discharges or earlier than appropriate discharges

High level of out of area placements which are especially problematic because of:
• delayed assessment, planning and commencement of care
• isolation of patient and therapeutic teams from family and carers
• practical difficulties of distance preventing transfer to community care when appropriate, management of living arrangements, post-discharge care planning
• lack of continuity with community care causes post-discharge care problems.
Regulatory interventions causing distortions in care:

• New-style CQC inspections and administrative reporting requirements are absorbing staff time and financial resources away from clinical work and patient care.
• Regulation is sustaining an institutional focus despite clear need for more integrated pathways of care to deliver improved ‘recovery-oriented’ cultures of care.
• Pressures of A&E wait targets are disrupting capacity to triage and admit on basis of acuity (i.e., hospital patient gets bed priority over a community-based patient).

Strategies suggested by our members to improve inpatient and alternatives to inpatient care include:

Managing bed resources better

• Ensure there are bed management forums involving clinical teams on a weekly basis.
• Ensure Home Treatment is closely linked to the wards to facilitate early discharge where possible and has capacity to respond with a high level of intensity.
• Flexible time scales for the reviews that can authorise discharge to prevent the ‘waiting for ward round’ scenario.
• Re-configure wards so that there is a short term assessment ward, which can develop processes and structures that are more suited to a rapid discharge.
• Create a good understanding of the purpose of admission for an individual, as often once that purpose is achieved, continuing acute treatment can be delivered at home.
• Strong links and presence of community teams in the wards to build new ways of partnership working.

Commission realistic bed numbers

• Work with commissioners to identify local demand and jointly monitor out-of-area placements.
• Commissioning on an activity rather than block contract basis or on an occupancy basis [85%].
• Invite commissioners to bed management meetings in order to support a mutual understanding of the pressure points and the changing acuity of care.
• Collate patient stories from those that do have to use an out of area bed, so that the experience is more clearly understood by commissioning groups.
• Ensure there is an adequate range of local inpatient provision, including acute inpatient units with a closely associated psychiatric intensive care unit (PICU), rehabilitation facilities with closely associated low secure facilities.

Managing the patient out of area

• Establish a clear system for out of area placements to ensure a speedy resolution can be found.
• Establish protocols detailing how a patient is kept informed of the process of finding a bed.
• Establish clear protocols and operational guidance in terms of ensuring there is regular review of patients that are out of area.
• Establish systems whereby contact with aftercare services is considered.
• Prioritise the return of out of area patients to a more local environment based on clinical need and assessment.
Improve organisational capacity around staffing and the ward environment

- Improve staff management processes – performance framework and appraisals, leadership development and training to deliver improved staff morale, skill mix, capabilities
- Make better and more innovative use of other disciplines of wards to develop a dynamic skill mix that meets the service user population needs more effectively
- Create developmental opportunities and diverse working experiences for staff (rotations, preceptorships)
- As in-community care rises, the level of acuity in inpatient care rises and so staff skills need to rise accordingly

Improving ‘poor’ alternatives to inpatient care

- Better access to inpatient and specialist care beds when needed, as suggested above
- Ensuring good communication about the need for an out-of-area bed and explanations to the patient about the reasons and how they will be supported
- Establish good understanding and plans of how the CHRTT is to support an individual with a strong emphasis on contingency planning should the situation deteriorate
- Closer working with in-community partners such as Housing associations, voluntary organisations and faith groups if appropriate to provide post-discharge support
- Improving primary care mental health capabilities and services and street triage services involving multiple partner agencies such as promoted under the Crisis Care Concordat
- Improve integrated working between inpatient teams and CHRTTs to ensure consistency and clarity of purpose of admissions, development of shared treatment goals, improved risk assessment and monitoring of care.

Q5.
In your opinion, what would be the best way of measuring ‘good quality’ care on an inpatient ward, or in an alternative to inpatient care?

In other words, what should we measure? And how should we measure it?

Our members suggested a wide range of quality metrics and factors that would help to develop a picture of the quality of care provided in the inpatient unit and through at-home treatment. Again, it is difficult to isolate individual factors, but they generally fall within the realm of process, feedback, outcome and effectiveness, and hard data. In addition, members emphasised that:

- Quality measures must be outcomes-focused and less process-oriented.
- For a true picture of quality, information must, where possible, be triangulated. In particular, there is a need to support current ‘mass’ collation feedback with more detailed, in-depth, focused service user, staff and carer evaluations to give a more objective view on the quality of the services.
• **Standard and capabilities of IT, data collection resources and administrative systems are insufficient** to meet the rising demand for more and better measurement and performance information about quality.

• **External assurance processes must allow a balance between the national standards and local staff being able to use a local dashboard** that enables them to take account of local variation and manage their service.

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<th><strong>Patient - Outcome measures</strong></th>
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<tr>
<td>• Patient by cluster</td>
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<tr>
<td>• Length of Stay – individual and by cluster</td>
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<td>• Well-being – Warwick-Edinburgh Wellbeing scale</td>
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<tr>
<td>• smoking cessation and other physical health improvement</td>
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<td>• engagement in recreational and therapeutic activities</td>
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<td>• results from Place assessments</td>
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<tr>
<th><strong>Patient - Experience measure</strong></th>
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<tr>
<td>• Service user satisfaction / service user engagement log (UEL) - real-time and post-discharge review</td>
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<tr>
<td>• Service user knowledge of care pathways</td>
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<tr>
<td>• Extent of patient and carer involvement in risk assessments and care planning (level of co-production)</td>
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<th><strong>Ward - Safety</strong></th>
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<tr>
<td>• incidents and ‘near misses’ at all levels</td>
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<td>• quality thermometer work including drug errors</td>
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<td>• nature of incidents and incident reviews</td>
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<th><strong>Ward – Staff feedback and staff issues</strong></th>
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<tr>
<td>• Staffing levels and appropriateness of skill mix/disciplines, temporary staff levels</td>
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<tr>
<td>• Burnout - The Maslach Burnout Inventory (Maslach et al 1996),</td>
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<td>• Staff knowledge of policy and procedure/criteria</td>
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<td>• Staff knowledge of patients</td>
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<td>• Staff’s rates of sickness</td>
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<td>• Frontline clinical staff feedback about strengths and areas requiring development</td>
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<td>• Staff Survey results</td>
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<th><strong>Ward - Standardised measures and scoring tools</strong></th>
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<td>• PANSS,</td>
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<td>• PsyRats</td>
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<td>• PHQ-9,</td>
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<td>• GAD-7</td>
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<td>• GAF’ CORE-OM/CORE-10</td>
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- TAG (Slade 2000)
- MANSQA (QoL)

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<th>Ward – management, procedures and protocols</th>
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<tr>
<td>• Appropriateness of information gathered from patients</td>
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<td>• Improved care throughout crisis and acute pathways with more seamless care provision</td>
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<td>• Use of risk assessment throughout CRHT and inpatient pathways</td>
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<td>• Diversion away from inpatient admission towards CRHT and the use of ‘hospital at home’</td>
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<td>• Use of multi-disciplinary care plans and goal planning</td>
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<td>• Good use of 1:1 protected time with named nurse, with clear goals and outcomes</td>
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<td>• % of admission and discharge summaries sent to GPs within 5 working days</td>
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<td>• readmissions and discharges out of hours (not of patient choice)</td>
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<td>• Quest data on quality</td>
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<td>• Staff completion of mandatory training and performance management processes</td>
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<th>Outcomes – Inpatient Ward</th>
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<tr>
<td>• Median Length of Stay</td>
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<td>• Number of re-admissions within 12 months</td>
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<td>• Ward Atmosphere – ward atmosphere scale</td>
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<td>• more informed ward rounds and handovers</td>
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<td>• % of delayed transfers of care</td>
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<td>• Out-of-area acute bed usage</td>
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<td>• % of inpatients seen by their care coordinator each week</td>
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<td>• % of inpatient discharges provided with early discharge support from IHBTT / CRHT.</td>
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<td>• Regular inspection of the environment</td>
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<td>• AWOL rates</td>
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<tr>
<th>Outcomes - At-Home Treatment / alternatives to inpatient</th>
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<tr>
<td>• % of IHBTT referrals seen within 4 hours</td>
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<td>• % of IHBTT service users assessed face to face by the IHBTT medical team within 3 working days</td>
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<tr>
<td>• % of admissions gatekept face-to-face by IHBTT</td>
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<tr>
<td>• Number of annual inpatient admissions per 100,000 working age adults</td>
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<td>• % of admissions admitted under MHA</td>
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<td>• % of inpatient admissions requiring admission for less than 7 days (i.e. subthreshold admissions)</td>
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<tr>
<td>• % of inpatient discharges provided with early discharge support from IHBTT</td>
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<tr>
<td>• % of IHBTT discharges that are re-referred within a certain timeframe e.g. 4 weeks</td>
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<tr>
<td>• % of assessment and discharge summaries sent to GPs within 5 working days</td>
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External scrutiny, feedback and quality assurance processes

- CQC and AIMS inspection results
- Complaints and compliments
- Friends and Family Test

Q6.

In your experience, do inpatient wards and alternatives to inpatient care services work well for all patients/service users? Or are there some groups (such as adults from some BME communities or other adult groups) that inpatient and crisis services do not work well for? Please give as much detail as possible.

A clear message from our members’ responses was that, due to the stigma attached to treatment in inpatient wards, that for all service users this should be reserved as a ‘last resort’ when patients require a high degree of supervision. However there are a number of groups of service users for whom inpatient wards can work well. This is the case for:

- prisoners with serious mental illness, as prison is an extremely counter-therapeutic environment;
- those suffering schizophrenia and bipolar disorder who are floridly psychotic and who need to be compulsorily detained; and
- those with an unclear diagnosis where a safe environment is needed for close observation.

Inpatient wards or alternatives can also work well for those service users who have disengaged and/or comply poor with medication, although it was acknowledged that community treatment orders may help manage these patients more effectively in the community. Also arranging admissions in situations where there is a high level of carer burden or strain factored in the responses: a brief inpatient stay can allow carers to reset their normal coping mechanisms.

There was consensus that the use of inpatient wards on an ongoing basis does not work well for service users with personality disorders for the following reasons:

- if used, at best should be only for a short, defined period of time which can help avoid inappropriate presentations to other clinical areas and critically avoid detention under section 136; a better alternative is specialist personality disorder units for high risk patients, including psychology-led inpatient/outpatient services;
- patients with personality disorder benefit from a clear pathway with clearly defined alternatives to admission, with the option of their own inpatient therapeutic community; and
- those with personality disorder with a history of repeated self harm should have an alternative place of safety to hospital beds;
- people with personality disorder who decompensate can need to be admitted, but this can quickly become counter-therapeutic if not managed properly. Effective management in this situation can be articulated as a staff group properly selected and trained in terms of knowledge, attitudes, values and
therapeutic skills alongside effective care planning, regular reviews of progress and meaningful support from specialist service.

Alongside those with personality disorder there are a number of groups for whom inpatient wards should not be a default response and community support would be more appropriate. These include patients with alcohol related problems without comorbid psychiatric illness, or patients with dementia who need more attention and/or one to one support.

More generally our members expressed the views that treatment overall works best when resilience has been built in the community, that the need for prompt treatment is recognised early and there is a focus on prevention. It was also clear that local inpatient services provide better care for the population they serve (rather than out of area) and can provide community care input from admission to discharge.

Q7.
We are keen to hear about any examples of good practice, service evaluations, research reports, data-sets, or other information that would help the Commission in its work.

Please take the opportunity below to let us know where we could obtain this information, including any contact details of the organisation/person that it can be obtained from.

NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high quality, patient focused, care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has 226 members – 94 per cent of all NHS foundation trusts and aspirant trusts – who collectively account for £65 billion of annual expenditure and employ more than 928,000 staff.

NHS Providers and our member foundation trusts and NHS trusts welcome and are very supportive of the recent progress made to improve the resourcing and provision of services for people suffering mental illness. As part of the drive to parity of esteem, the impact of historic underfunding; inadequate payment systems and tariff; block contracts; and ineffective and poorly planned commissioning for mental health services must all be addressed if the quality of service provision for mental health patients is to achieve the consistently high standard of NHS care and outcomes for mental health service users and patients as for physical health.

Our response to this consultation has been informed by the direct feedback and experiences of our member trusts, and we are in particular very grateful to the following organisations that provided information to support this submission:
- North Staffordshire Combined Healthcare NHS Trust
- North Essex Partnership NHS Foundation Trust
NHS Providers is keen to contribute to the Commission's work. We would be happy to meet with you or give further evidence in any face to face sessions you hold.

As noted above in our responses to questions 2 and 3, several of these trusts have provided us with detailed case studies to serve as good practice examples. We have included these for the Commission's reference at Annex A. These trusts would be very happy to share further information about these practices with the Commission if of interest and we would be very happy to facilitate this engagement. For further information please contact Cassandra Cameron, Policy Advisor, NHS Providers at: Cassandra.cameron@nhsproviders.org.
ANNEX A: 
Examples of good inpatient care and alternatives to inpatient care

**Oxford Health NHS Foundation Trust**

Oxford Health NHS Foundation Trust has recently opened a brand new, purpose built mental health and wellbeing campus in Buckinghamshire where the inpatient and community teams are co-located. This enables true partnership working between the teams on a 7 day/week basis and gives patients access to other support services which are on site. The environment meets all privacy and dignity standards, allows patients safe outdoor access and facilities for recreation and socialising. Each ward (2 adult acute) has a separate S136 suite which has external access and a discreet entrance for patients being transported to the suite.

Each ward is consultant led, in conjunction with the ward manager and the modern matron. These three postholders have all undertaken specialist leadership training and provide senior level clinical and managerial support to their teams.

The environment of this new building is a huge contributory factor to the level of care that we can provide here, and staff and patient feedback from the inpatient wards based there has been consistently high. This has been reinforced through formal and informal comments through our AIMS accreditation process and from local CQC visits. There is huge value in working in partnership with the community services and promotes a clear pathway for patients that has flexible options to support their individual needs. There is true community engagement with a range of support provided by the 3rd sector and other local organisations which establishes a genuine sense of trust and expertise from the patient perspective.

**Pennine Care NHS Foundation Trust**

Examples of good alternatives to inpatient care in Pennine include the work developed and implemented as part of the Crisis Care Concordat principles. This includes the development of local street triage initiatives that allow decision making to be made further upstream between professionals from both ambulance and police services with qualified experienced mental health practitioner. This offers an alternative to attending hospital, use of section 136 and more effective and appropriate pathways to be utilised.

In relation to good examples of inpatient care the adult acute wards in Pennine Care have all invested over recent years in the development of the therapeutic week. This has included a full therapies programme tailored to meet the needs of the service users on the acute wards, from Multi use Gym Equipment both in and outside spaces as well as distraction groups and
more focussed therapy groups and one to one sessions this has allowed a more therapeutic experience for the service users on the wards in Pennine.

The reason both these examples are offered as positive is because they both take principles devised through national consultation and feedback and actually make this a reality. It has been said that ‘the ideas embodied in innovative social programmes are not self-executing’ (Petersilla, 1990). Pennine have recognised this and in order to make a good idea a reality it takes programmes of implementation and a drive to deliver for the best outcomes that can be achieved and it is for this reason these two good examples are offered as such.

South West Yorkshire Partnership NHS Foundation Trust

South West Yorkshire Partnership’s acute service has implemented a robust patient flow management system with detailed weekly meetings in which senior inpatient clinicians and our IHBTT link worker discuss the management of all inpatients.

Police street triage pilot is being conducted during twilight hours to improve patient care and reduce the number of detentions under S136.

New IHBTT referral pathways developed for out-of-hours urgent referrals by GPs and ambulance staff to prevent unnecessary, distressing and lengthy attendances at A&E.

Needs-led, ageless IHBTT service since 2011 supported by weekly meetings with senior clinicians from Older Persons’ CMHT. Admission rates have reduced by 10-15%.

Community alternatives to traditional admissions include community perinatal pathway, community clozapine initiation and community based ECT provision.

This allows ALL patients to be given the option of intensive home treatment as an alternative to inpatient care. Closer liaison between police and criminal justice system and better integration of MHA assessments into the acute pathway help divert potential crisis admissions. Improved communication between crisis services and community provision supports people in the community during crisis.

Cheshire and Wirral Partnership NHS Foundation Trust

Cheshire and Wirral Partnership NHS Foundation Trust (CWP) considers that good inpatient care needs to deliver a biopsychosocial model of multidisciplinary care.
The role of inpatient care needs to be part of a pathway of care that moves seamlessly from Community mental health team, home treatment to inpatient care. There needs to be clarity of purpose of inpatient care eg management of risk that cannot be mitigated by community care, complexity of care needs that cannot be met in the community. Clarity of use of inpatient beds has ensured effective and efficient use of beds at CWP (in lowest quartile nationally for beds, bed days, admission rates, delayed transfers of care). Only on 1 occasion in the last 7 years has CWP admitted a patient outside its Trust footprint.

In CWP, support to inpatient staff teams for patients with an inpatient stay over 40 days by a central expert team, the CRAC team (Complex recovery and consultation service) has improved the care pathway for adult inpatients with complex needs. This has ensured that patients with longer lengths of stay have an automatic second opinion and ensures that inpatient care team are given advice and support of alternatives to support effective care. Availability of community crisis beds has supported the reduction in Acute beds and has resulted in improved patient satisfaction and empowerment.

Provision of home treatment services have ensured patients are cared for in the least restrictive environment. This is valued by patients and carers. However it is important to ensure home treatment services are not “diluted” to provide care to an ever increasing volume of patients without increasing resources in line with population needs. Lack of effective community options results in significant variation in delivery of inpatient care.

Availability of MH Liaison services ensures effective care management of those presenting to AED, to support inpatient bed usage.

Organisational culture to ensure staff work with patients and carers to deliver collaborative care ensures that discussions about risk management supports the delivery of safe and effective care in the least restrictive setting. Organisational culture which works to deliver inpatient services within Trust footprint are embedded into clinical delivery.

Greater Manchester West Mental Health NHS Foundation Trust

Over the past 2 years Greater Manchester West MH NHS Foundation trust (GMW) has critically reviewed and clinically redesigned its acute psychiatric care for adults of all ages. One of our key indicators was that 60% of relatively short inpatient admissions were occurring outside the hours of 9-5 Monday – Friday. The obvious conclusion was not that people were more ill then, but that our community services were not structured or extensive enough to offer the comprehensive service required.

The work to redesign services started from the premis of “what should first class community services look like” rather than “which beds should we shut where”. However, there was a
reality touchstone in the work too. Cost Improvement Programmes are increasingly difficult to find in a “marginal way” and this “root and branch” review also had to reduce costs.

The redesigned Acute Care Pathway offer has therefore delivered the following:

a) Community Mental Health Teams – previously working Monday-Friday 9-5 – now work 8 am-8pm Monday-Friday and 9-5 Saturday and Sunday.

b) The Crisis Teams have been redesigned and significantly expanded and we have abandoned the word “crisis” and adopted the name of “Home Based Treatment”. This multi-disciplinary service works 24/7 and the service is modelled to enable capacity to ensure individuals can receive up to 3 intensive visits in any 24 hour period. This both avoids admission and accelerates safer discharge.

c) A seven day telephone helpline has been implemented for “known” service uses to enable instant access for talking to a professionally qualified member of staff.

d) Resource issues – the Community Developments were “pump-primed” by the provider Trust with non recurrent resources of just over £1 million. The redesign enabled the closure of 50 beds, which released £3.5 million per annum revenue. Of this £1.3 million was recurrently reinvested to expand the community services and the remaining £2.2 million supported the Trust’s CIP. No recurrent or non recurrent resources were sought from commissioners, just their support for the public consultation required. Despite the local CCG and LA strategic intent to reduce costs and deliver more care closer to home in all specialities, the consultation was difficult. Union negotiations were also extremely challenging, but ultimately delivered. There was a complex redeployment, retraining and recruitment exercise undertaken. There was no compulsory redundancies, many ward staff choosing actively to “retrain” for the community opportunities.

e) The Trust has also used significant capital to improve the physical environments of the remaining wards, PICUs and also built purpose designed Section 136 facilities. The latter had been a contentious and unresolved issue between various commissioners and Acute Trust A&E departments. The Mental Health FT has bridged these by offering practical solutions and resources and working in partnership with the Police.

f) The Trust is now actively monitoring the increased acuity of patients post these changes and testing its previous assumptions to ensure staffing levels and skills on the acute wards are able to offer safe and therapeutic care.
North Essex Partnership University NHS Foundation Trust

Journeys Programme

The Journeys programme has been nearly four years in the planning and has involved staff at all levels designing a new system and modelling how we use staff skills to deliver a simpler, more efficient service.

Journeys, put simply, is about providing an improved community service for service users, for commissioners, for referrers and for staff. It is also about using our skills, expertise and resources in the most efficient way. In short, we introduced just one single front door access, to make it simpler for referrers. Service users will have one comprehensive assessment upon entering our services so they don’t have to keep repeating their story.

We have fewer handovers and simpler pathways. Specialist care and treatment teams work collaboratively, both within their own pathway and in communicating with other teams. This puts us in a strong position for future integrated working and competing for new contracts.

The majority of staff agreed during consultation that the service had to change. Most agreed that the introduction of clear, clinical pathways will make a positive difference to the way service users experience our services.
Treatment Care Packages

For each service user, we are commissioned to deliver an individual package of care and treatment based on their mental health care cluster. A choice of interventions should be available in each cluster care package and these should be evidence-based and aligned to NICE guidance.

Based on the new patient pathways through the service, we have worked with clinicians across disciplines to draw together a comprehensive set of evidence-based interventions/therapy for each cluster of service user. These are explained in detail in later sections of this guide. The care package details forms the agreement for care and services between the Trust and our commissioners.

Underpinning Principles

From the very start, we identified five key principles that must underpin our services. To deliver against these principles we need a new system, driven by a new vision, a different culture and our new set of Trust values which means embracing a new way of working.

- **Responsive** – a responsive, expert access and assessment service through a single point of entry, effective planning and delivery of specialist evidence-based treatment and support for those requiring secondary mental health care.
• **Effective & Safe** – planning and delivery of treatment and care underpinned by agreed evidence-based holistic treatment and care packages that offer a choice of interventions to service users and their families

• **Person-Centred** – service delivery based upon the identified needs of the individual. Services delivered in the setting and by the professionals most appropriate to the needs of the individual. There will be a flexible approach to the use of the Care Programme Approach (CPA) with the option to use either a CPA or non-CPA based approach as appropriate

• **Streamlined** – clearly described care pathways, explicitly specified in detail, that inform the work of all professionals. Bottlenecks, duplication, waste and delays avoided. Accurate information recorded that informs the measurement of outcomes and transparent capacity and demand management

• **High Quality** – organisational policies and procedures which proactively drive an organisational culture that is genuinely underpinned by compassion, clinical excellence and a genuine sense of service to all our stakeholders

**Practice Development**

Trust has a well-established partnership with Bournemouth University having obtained Trust wide accreditation against Practice Development Unit Standards (PDU) in November 2014. PDU is a broad term that covers a range of approaches to improving the way in which we deliver care to service users.

Teams are encouraged to question and challenge current practice; improve services based on evidence and share excellence in practice internally and externally. In gaining accreditation the Trust has already demonstrated that our practices are robust and diverse with greater clarity around the way in which care pathways are defined and the dual focus on skill mix and clinical effectiveness.

**A Safer Service**

Most NHS organisations tend to have a reactive approach to patient safety, learning from past mistakes. In other high risk industries such as aerospace and nuclear power, a proactive method of prospective hazard analysis (PHA) is used to ensure a more proactive approach that aims to predict and mitigate risks before problems occur. These PHA approaches are currently little known or used in the NHS, but a programme led by Professor John Clarkson at the University of Cambridge aims to change this.

Professor Clarkson and his colleagues have developed a PHA toolkit for use in the NHS. In contrast to the current, dominant, reactive approach of learning from past errors, the PHA toolkit it is both proactive and predictive. The approach demands a different mind-set and organisational culture
relating to risk. PHA is not a single method but rather an approach and a range of tools. PHA methods are systemic, systematic and structured processes that support the identification of hazards, their potential consequences and hence risk. PHA draws upon existing system performance and failure data but also on subjective sources of risk information.

Around fifty Trust staff have been trained to use PHA techniques by Professor Clarkson and his colleagues at an earlier stage of the Journeys programme. These methods were used to review the proposed care pathways while being developed. In preparation for the new services to ‘Go Live’ trained staff are encouraged to use these techniques to continue to identify how to continue to reduce risk from the new clinical pathways. All new teams are required to develop and maintain a detailed issue and risk log identifying both known and prospective hazards.

A Compassionate Service
Compassion is at the centre of all we do and the Trust wants to support our staff and promote a culture and environment where compassion can flourish. As such compassion was a ‘Big Issue’ considered at an early stage of the Journeys programme.

Building on the work of this group, last year the Compassion Steering Group, chaired by the CEO, agreed to launch and support the Schwartz Rounds initiative. Schwartz Rounds are a practical tool for health and care providers to improve the culture of their organisation and support staff through the use of reflective practice. We have already had a series of successful Schwartz Rounds. Originally developed by the Schwartz Centre for Compassionate Healthcare in the USA, Rounds have been implemented in more than 320 organisations in the USA and 30 organisations in the UK. The Point of Care Foundation, which grew out of the work of the Point of Care programme at The King’s Fund, is the sole provider of training and support to organisations running Schwartz Rounds in England and has been working closely with the Trust.

A System Approach

“Places that function most like a system are the most effective’. Atul Gawande

Atul Gawande is a practising American surgeon and Professor at the Harvard Medical School, and was named by Time magazine in 2010 as one of the world’s most influential thinkers. He argues that whilst health organisations have good components i.e., top quality clinicians and technicians, there is little consistency of coming together to provide an actual system of care, from start to finish.

“By a system I mean that the diverse people actually work together to direct their specialised capabilities toward common goals for patients. They are co-ordinated by design. They are pit crews’

Our vision of a team approach echoes this idea of a ‘pit crew’ mentality; a true sense of teamwork, discipline and humility. This approach is not new. It has been used by CRHT and AOT with strong
evidence that it works. Teamwork should be about a shared understanding that working truly collaboratively as part of a prescribed system of care will mean clinicians are less exposed to failure and negative stress than as an individual practitioner and are better supported and therefore have greater combined skills to improve the outcomes of service users.

The pit crew approach is about having tightly organised teams with everyone assigned specific roles and communicating constantly. It is also about being flexible, pragmatic and being responsive to demand. The culture we want to build is around shared responsibilities, where pathway teams are supported clinically and managerially, are supportive of each other, feel valued and have a sense that what they are doing collectively makes a real difference to the lives and experience of service users.

Working in this takes courage and commitment.

**Hertfordshire Partnership University NHS Foundation Trust**

We have a great example of an alternative to in-patient care that has been in operation for the past 3 years the Host Family service: This service is provided by ordinary families in Hertfordshire who have been trained and are supported by professional staff to provide company and a temporary home for individuals suffering from conditions including anxiety and depression. This helps prevent them going into hospital or acts as a halfway house after they have been discharged into the community.

All the clients are screened to make sure they are suitable for a host family and a CATT Community Psychiatric Nurse visits on a daily basis with regular follow-up from the Consultant Psychiatrist and / or Specialist Registrar.

The project, which has won a national award, is based on a French model of care. There are currently 8 families offering this support.

The reason this is such a good example is the multi-faceted benefits the care has. It benefits the service user by enabling them to remain connected to the local community and have high quality support in a time of crises. It benefits the host family who become more skilled and knowledgeable in the field of mental health issues and can see the impact that their skill and training can have on the lives of others – giving them a real sense of achievement. It also benefits the local community by building resilience in the community around mental health issues, their understanding of these and how to deal with them and reduces the stigma in the community as well.
Birmingham and Solihull Mental Health NHS Foundation Trust

Birmingham provides a pan-city Home Treatment service with the result that our rate of admissions is very low compared to benchmarked trusts. The service consists of teams led by Consultant Psychiatrists which relate to a set of GP practices. The teams aim to both avoid admission by providing treatment either at home or in respite beds and to shorten admission by facilitating early discharge.

The teams are multi-disciplinary and include input from psychologists and occupational therapists.

In collaboration with third-sector partners the trust provides crisis houses which allow short-term accommodation which is staffed by voluntary sector workers and supported by the trust’s home treatment and assertive outreach teams. These provide an alternative to admission for people with mental health problems in crisis whose risk assessment allows for them to be cared for in a domestic environment.

The trust is currently piloting a Psychiatric Decisions Unit. This is open 24/7 but provides care for up to 12 hours (there are no beds). It primarily serves the local A&E departments taking patients who have been seen by RAID (psychiatric liaison service) but for whom no immediate resolution is available in the A&E department. Patients who are uncooperative or behaviourally disturbed are not admitted to the unit and it only admits adults.

Clinical input is led by Consultant Psychiatrists who work on a sessional basis (one evening session on weekdays and two on weekend days. The unit was originally commissioned from winter pressures money as a short-term measure but commissioning has been extended.

In collaboration with police and ambulance services, a “street triage” car provides a multi-disciplinary response to community crises, frequently via the 999 service.

This network of services working in partnerships provides tremendous flexibility to respond to various crises. The low admission rate which the trust has demonstrated by in recent benchmarking and the low number of beds which the trust has demonstrate that the services provide a real alternative to acute admission.

North Staffordshire North Staffordshire Combined Healthcare NHS Trust

A dedicated functional acute home treatment team that is part of the managerial and clinical structures of the acute inpatient units provides a direct structure for sharing values, culture, and procedural arrangements and opportunities to resolve disagreements, whilst protecting the community experience, risk management culture and resource necessary to deliver acute care in people’s homes.
Where risk management and patient consent allows, the service offers several visits a week, medications management / administration and multidisciplinary reviews in the patient’s own home to deliver the level of assessment and treatment interventions to help resolve episodes of acute mental illness/distress. The team operates from a competence enhancement base, informed by solution focused brief therapy techniques whilst attending to responsibilities for continued risk assessment / management. Additionally the team offers support with some of the practical issues that can often arise through an episode of acute mental health distress.

Close communication structures and procedures with community mental health teams support mutual understanding and timely discharge from acute home treatment to maintain capacity within the acute home treatment service.

The model works well as supported by a separate functional access team that offers a primary care triage service, which helps to manage the inevitable requests for general assessment and crisis response that the service was exposed to prior to this triage service. This ensures that the maximum use of the resources available to acute home treatment are utilised in providing home treatment.

Between the hours of 11.00pm and 8.00am the functions of home treatment and triage are amalgamated to ensure the best value for money.

Currently there is an enhanced presence of staff that have very recent experience of acute home treatment in the Access team and this has allowed a trial period of whether the gate-keeping function relating to admission can be provided successfully by the access team, which again should allow greater opportunity to maximise the resources allocated to acute home treatment to provide the requisite treatment for patients. However the longer term impacts of not having gate-keeping within home treatment is still under regular review.

Black Country Partnership NHS Foundation Trust

Black Country Partnership NHS Foundation Trust were pioneers in having a designated Home Treatment Team for the elderly which has prevented a number of admissions and deliver care closer to home.

For Wolverhampton locality the trust manages it population with fewer inpatient beds compared to the national average for the population. This is achieved through robust community care and an effective Home Treatment Service for the younger and older people. The threshold for admission is set at the right level for admissions. The length of stay is average and in the past year and working closely with Local Authority has reduced Delayed Transfer of Care.
The Sandwell locality has seen a reduction in inpatient bed number achieved through the closure of one ward for older people which created an opportunity to invest in enhancing community support, including the development of a crisis home treatment team for older adult in Sandwell.

In addition the Trust has developed the role of Psychiatric liaison services across two acute Trusts with a significant impact on the following:

• Improved access to services
• Improved timeliness of assessment
• Inpatient support for patient requiring mental health involvement
• Reduced Length of stay
• Education and support of staff.
• Reducing burden on community teams,
• Improved standard of care
• Reduce re-attendance rates
• Reduction in self-harm rates
• Reduction in length of stay
• Dedicated environment improving the experience of those who present at ED

Psychiatric Liaison service demonstrates an approach to partnership working and the development of improved patient pathways and the mental health liaison service in Sandwell ‘Oak Unit’ was shortlisted in the Royal College of Psychiatry Award 2014 in the category of Psychiatric Team of the Year - working age adults; this was for the following reasons:

• Ensuring responsive assessments and plans of care.
• Better engagement with patients and families. Provide urgent needs led assessment and safe discharge for patients.
• Offering a direct referral service, a point of access for people who are experiencing mental health/emotional crisis within an acute hospital setting
• Offer assessment of needs and robust discharge planning
• Improve the experience of people with mental health crisis in a acute hospital.
• Promotes dignity and person centred care
About you (please complete in full)

Q8. Please provide your full contact details below. We will not use these for any other purpose than to understand who has responded to the consultation, and to produce an overall ‘count’ of the different types of respondents. We will not share your details with any other organisation.

<table>
<thead>
<tr>
<th>Your name:</th>
<th>CASSANDRA CAMERON</th>
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<tbody>
<tr>
<td>Your job title (if relevant):</td>
<td>POLICY ADVISOR</td>
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<tr>
<td>Organisational name (if this applies):</td>
<td>NHS PROVIDERS</td>
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<td>Address:</td>
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<td>Post code:</td>
<td>SW1H 9JJ</td>
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<tr>
<td>Email:</td>
<td><a href="mailto:Cassandra.cameron@nhsproviders.org">Cassandra.cameron@nhsproviders.org</a></td>
</tr>
<tr>
<td>Telephone number:</td>
<td>020 7304 6814</td>
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</tbody>
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Q9. Are you replying to this consultation:

- ✓ on behalf of an organisation?
- □ as an individual?

Q10. Which of these best describes your experience of, or interest in, inpatient mental health care:

- □ As a patient, service user, or survivor
- □ As a carer or family member
- □ As a member of staff in a mental health service (NHS, independent, or voluntary)
- □ As a provider of mental health services (NHS, independent, or voluntary)
As a commissioner/planner of mental health services
☐ As someone involved in health or social care outside of mental health (clinical and managerial)
✓ As a charity or voluntary sector organisation with an interest in this area
☐ As an organisation or individual working in the criminal justice system
☐ As a Local Authority body (or an individual working for them)
☐ Other (please specify)
___________________________

Q11a. Thinking about the answers you gave in this consultation, where has your experience of inpatient services/alternatives to inpatient services mainly taken place?

✓ England
☐ Wales
☐ Northern Ireland

Q11b. And in which region? n/a

☐ North East England
☐ North West England
☐ Yorkshire and the Humber
☐ East Midlands
☐ West Midlands
☐ East of England
☐ London
☐ South East England
☐ South West England

☐ West Wales/Valleys
☐ East Wales
☐ Outer Belfast
☐ North Wales
☐ East of Northern Ireland
☐ Mid Wales
☐ North of Northern Ireland
☐ South West Wales
☐ West and South of Northern Ireland
☐ South East Wales

Q12. Would you be happy for us to contact you to ask for further information about your response?

✓ Yes

Finally, if you are replying as an individual (rather than as an organisation):

Q13. What is your gender?

☐ Male
☐ Female
☐ Transgender
☐ Prefer not to say

Q14. Please tick your age group

☐ 19 or under
☐ 20 to 29
Q15. Would you consider yourself to have a mental health problem?

- Yes – I would consider myself to currently have a mental health problem
- Yes – I would consider myself to have had a mental health problem in the past
- No
- Prefer not to say

Q16. How would you describe the area in which you experienced inpatient care?

- City
- Rural
- Town
- Inner city
- Suburban
- Prefer not to say

Q17. How would you describe your ethnic origin? Please tick one box only.

**White**
- White – English/Scottish/Northern Irish/British
- White – Irish
- White – Gypsy or Irish Traveller
- White – any other White background

**Mixed/multiple ethnic groups**
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed/multiple ethnic background

**Asian/Asian British**
- Indian
- Pakistani
- Bangladeshi
- Chinese
☐ Any other Asian background

**Black/African/Caribbean/Black British**

☐ African

☐ Caribbean

☐ Any other Black/African/Caribbean background

**Other ethnic group**

☐ Arab

☐ Any other ethnic group

☐ Prefer not to say

Thank you for your help

Please return this questionnaire by 18th March to: consultation@CAAPC.info

If you have any questions about the Consultation or about the Commission, please contact information@caapc.info