

# Defining mental health services

Promoting effective commissioning and supporting QIPP



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# Foreword

Health and social care commissioners and service providers are focusing on the importance of quality and productivity as ways of ensuring better outcomes, improved service models and effective interventions.

Doing this requires a clearer understanding of the types of services currently provided, an understanding that is shared across the system. In mental health there has not been a consistent set of definitions that describes what is meant by an inpatient bed. This has led to difficulty in benchmarking and understanding patterns of performance.

This report seeks to address those variations of understanding by suggesting a range of definitions that can be used by commissioners and service providers. The work to develop the definitions has benefited from the contributions of a range of experts in the field of mental health.

We would like to thank the following key stakeholders for supporting this report:

- The Association of Directors of Adult Social Services (ADASS)
- The NHS Confederation
- The Royal College of GPs
- The Royal College of Nursing
- The Royal College of Psychiatrists.

These definitions are being piloted with a view to future implementation. We hope that in the meantime organisations will want to draw upon them, and that by defining services in this way we can enable effective and consistent decision-making about service redesign.

**Jim Symington, Chair of Task and Finish Group on Mental Health bed definitions**

# Executive summary

In mental health there has not been a consistent set of definitions that describe what is meant by an inpatient bed. This has led to difficulty in benchmarking and understanding patterns of performance.

Understanding how inpatient beds and community services can best be utilised as part of a reshaped pathway, and whether the number of beds can be further reduced over time, with an appropriate mix to meet local need, is a key component in a commissioner's knowledge base.

Quality and productivity improvements should not just be about reducing beds. They should be about ensuring the right number and mix of beds in the right place with the right level of support, based on an agreed definition and common understanding of what each set of beds or services is for.

Bringing greater consistency to both language and understanding in respect of defining services will enable decision making about service redesign to be more consistent and based on a set of definitions that are well understood and accepted across the system.

# Introduction

In March 2011 the National Mental Health Development Unit (NMH DU), in collaboration with strategic health authority (SHA) mental health leads, commissioned a short, focused piece of work to develop a set of definitions for mental health inpatient services. The work was supported by a small group of specialist clinical and data advisers and the discussion paper arising from the work was published at the end of March, just prior to NMH DU ceasing operations.

Since then, a number of people who were involved with that work have continued to discuss how best to take forward the definitions themselves, alongside whether to develop some additional areas of enquiry relating to beds that are provided outside traditional hospital settings, in order to support the mental health commissioning and the Quality, Innovation, Productivity and Prevention (QIPP) agendas.

The Department of Health, in partnership with the Mental Health Network of the NHS Confederation and the Joint Commissioning Panel for Mental Health (JCPMH) and SHA mental health leads, commissioned a second phase of work that started in July 2011.

The previous paper has now been updated to include additional definitions to complete the 'pathway' and includes some community-based services that are not funded directly by the NHS:

- 24/7 residential and nursing home care
- supporting people services (housing and housing-related support)
- living at home with a care package
- crisis accommodation
- inpatient dementia assessment services.

The limitations of the current paper leave further potential to agree definitions for beds for older people with a functional mental illness, a range of specialist beds and other community services which make up mental healthcare pathways.

The definitions set out in this paper have been endorsed both by the members of the original advisory group and a range of key stakeholder organisations. These include:

- The Audit Commission
- ADASS
- The Department of Health
- The Mental Health Network of the NHS Confederation
- The NHS Information Centre
- The Royal College of GPs
- The Royal College of Nursing
- The Royal College of Psychiatrists
- SHA mental health leads.

The overriding principle of this project is its recognition that productivity improvement and redesign processes should not just be about reducing the number of beds per se. Rather, they should be about ensuring the right number and mix of beds in the right place with the right level of support, based on an agreed definition and common understanding of what each set of beds or services is for.

It is hoped that attempting to bring some consistency to both language and understanding in respect of defining services will enable decision-making about service redesign to be based on a set of broadly agreed, consistent definitions.

Work has also been done to identify NHS organisations who can pilot the definitions over a three-month period. At the same time, discussions are being held between the Department of Health and the NHS Information Centre about how to establish the ways in which key resources, applications and indicators should be adapted to take advantage of the new definitions.

# Background

Mental health services in England have developed substantially over the past decade. The National Service Framework (NSF) for mental health was a key lever in delivering improvements. The associated policy implementation guide (PIG) set out a range of service models that commissioners and providers adopted as part of a process for developing new teams, mainly in community settings. The PIG set clear criteria and definitions for those services, describing their workforce composition, aims, objectives and targets for the number of interventions in any given locality. The definitions of the service models were deliberately prescriptive and based on the best international evidence at the time. The key aim was to provide home and community-based services as a safe, high-quality alternative to 'bed' use. Although there was a degree of flexibility, there existed a broad consensus about the definition of each service, no matter where in England it was being delivered.

The NSF concentrated in the main on community-based services for people with severe and enduring mental ill health. It included crisis resolution and home treatment, assertive outreach and early intervention teams. Although there was reference in the NSF to inpatient services and the publication of some guidance, there was less emphasis on the inpatient environment and on rehabilitation services in either the health or social care sectors. The consequence of this has been an underdeveloped understanding of what certain bed-based, often inpatient and accommodation services do, and whom they serve.

**'The key aim was to provide home and community-based services as a safe, high-quality alternative to 'bed' use.'**

**'Despite the publication of some guidance in the last few years, there was no clear or endorsed definition of inpatient beds across the different service sectors. For instance, the definition of an acute inpatient bed can differ from provider to provider.'**

Despite the publication of some guidance in the last few years, including the development of the Acute Care Declaration<sup>1</sup>, there was no clear or endorsed definition of inpatient beds across the different service sectors. For instance, the definition of an acute inpatient bed can differ from provider to provider. In addition there has been no agreed definition of a number of other services that are delivered in community settings, or by organisations that are not part of the NHS, such as local authorities and independent or voluntary sector bodies.

This means that it is harder for commissioners to know if they have the right service in place, or indeed the right mix of beds for each particular element of their local services. As there are major differences in funding implications of the different bed types across the pathway, this is a key QIPP area for commissioners, and currently there is virtually no bed-specific information available to inform their productivity, value for money and outcomes. This also causes difficulty when attempting to benchmark services collectively to establish patterns of performance, quality and productivity.

In this context, an inpatient service is defined as a unit with 'hospital beds' that provides 24-hour nursing care. It is able to care for patients detained under the Mental Health Act, with a consultant psychiatrist or other professional acting as responsible clinician. This does not mean that all, or even a majority of, patients will be detained. All units should have access to the full range of skills of the multi-professional team.

Such a unit may be in a hospital campus or a community setting. Such inpatient units may be provided by NHS or independent sector providers. Day-to-day needs for food, utilities and so on are provided by the 'hospital' rather than by benefits.

Beds (inpatient) need to be distinguished from placements registered for the provision of care. These are provided by local authorities and independent sector providers and registered by the CQC. They provide accommodation, usually a room in a multiple occupancy facility, and a care/support package funded by health and social services (occasionally privately). This affects residents' benefit status and they are not tenants.

**'All three elements – beds, placements and home support – are essential for an efficient and effective mental health service.'**

The third major element of a spectrum of mental health services are community or home-based support services. These are generally provided in a patient's home where they have a tenancy, ownership or other right to reside in the property, for example a family home. Funding of the accommodation, such as via housing benefit, is independent of the support provided, which may come from a variety of sources, health, social care, or independent sector. At times a range of agencies may provide support to the individual simultaneously. Funding for food, utilities and so on is from benefits or earnings.

All three elements – beds, placements and home support – are essential for an efficient and effective mental health service, although the configuration of such services will vary widely according to local circumstances and needs. A deficit in one, for example in residential care, may need to cover usage of another, such as acute psychiatric hospital admissions. All need to form part of a comprehensive system, but the focus of this updated paper is the definition of various types of inpatient and community services.

Clinicians, managers and commissioners certainly all believe that they have an understanding of what is being described when using, for example, the term 'acute inpatient service', but there remains considerable variance in that understanding and practice across the country.

# Context

This work has its roots in a longstanding dialogue between clinicians, managers and commissioners, who have collectively been seeking ways to better define the services they provide and commission. There is a broader context, however, specifically the need to ensure improved quality and productivity in local services.

The development of Quality, Innovation, Prevention and Productivity (QIPP) as the framework that the NHS, in partnership with local authority colleagues, is using to create the changes needed to commission and deliver effective and efficient health services, has highlighted this definitional deficit in relation to mental health inpatient services.

This work considers some of the obstacles and opportunities that might affect commissioners and providers, changing the way in which they use both inpatient and community resources. As an example, it is well recognised that there is wide variation in bed usage across the country, even after adjusting for the needs of different populations.

**'There is wide variation in bed usage across the country, even after adjusting for the needs of different populations.'**

Understanding how inpatient beds and community services can best be utilised as part of a reshaped pathway, and whether the number of beds can be further reduced over time by using an appropriate mix of services to meet local need, is a key component in a commissioner's knowledge base. This is especially the case when it is anticipated that changes in the number and mix of inpatient beds or community-based services could assist in the development of more effective and efficient services that can deliver improved outcomes for patients, as well as improving productivity for providers and commissioners.

# Methodology

The project has used a mixture of desk and fieldwork study to gather the information used to compile the definitions.

The engagement of appropriate specialist advice has been particularly important. Clinicians and managers have participated in a virtual focus group to provide advice, information and examples of definitions.

Where definitions or guidance already exist, the project has used these in their original form or sought to amend them to reflect current clinical and operational opinion and practice.

## Advisory input

This work has been supported by input from a small group of experts whose expertise lies in the clinical, managerial and performance management of commissioning, service delivery and performance monitoring.

**'Clinicians and managers have participated in a virtual focus group to provide advice, information and examples of definitions.'**

The group included:

- Elizabeth Allen, QIPP lead, Secure Services
- Prof June Andrews, Dementia Services Development Centre, University of Stirling
- Steve Appleton, Contact Consulting
- Prof Sube Banerjee, Clinical Director (Mental Health Officer Award), South London and Maudsley NHS Foundation Trust
- Dr David Bridle, East London NHS Foundation Trust
- Dr Denise Cope, Old Age Psychiatrist, Dorset Healthcare NHS Foundation Trust
- David Daniel, Department of Health (Mental Health Division)
- Dr Steffan Davies, Northamptonshire Healthcare NHS Foundation Trust
- Glynn Dodd, South West London and St George's NHS Trust
- Dr Michele Hampson, Nottinghamshire Healthcare NHS Trust / RCPsych
- Netta Hollings, NHS Information Centre
- Dr Helen Killaspy, University College Hospital
- Dr Janet Parrot, Oxleas NHS Foundation Trust
- Dr Geraldine Strathdee, NHS London and CQC
- Jim Symington, Symington-Tinto Health and Social Care Consultancy
- Tracy White, Central and North West London NHS Trust.

# Definitions

## Acute inpatient bed

The most well-known and used type of bed or ward in adult mental health is the acute, in this case, an acute bed for adults of working age (18–65) for males or females. Our definition is based on the 2000 service mapping for working age adults.<sup>2</sup>

Acute inpatient wards provide care with intensive medical and nursing support for patients in periods of acute psychiatric illness. In order to provide evidence-based care a full range of disciplines, including pharmacists, psychologists, occupational therapists and housing and social care colleagues, need to be commissioned.

Patients will usually spend fewer than 90 days on an acute inpatient ward, although problems with discharge may mean that this is not achieved in practice. Patients may be informal or subject to the Mental Health Act. These wards are now expected to meet the single sex accommodation standards. Some areas will sub-divide acute wards into assessment and short-term admission and longer-term treatment wards.

This definition makes the specific exclusion of the following services:

- wards for adolescents and excluding wards specifically for older adults
- any wards or beds allocated for very specialist functions, such as:
  - eating disorder beds
  - learning disability beds
  - national specialist services, such as obsessive compulsive disorder (OCD), anxiety disorders
  - mother and baby unit beds for perinatal psychiatry
  - residential psychotherapy for personality disorder
  - other specialist beds, such as autistic spectrum
- any forensic medium, low secure or psychiatric intensive care unit wards
- any wards specifically designated for rehabilitation
- crisis house or respite beds
- inpatient substance misuse units.

# Psychiatric intensive care unit (PICU)

A PICU is a type of psychiatric inpatient ward. These wards are secure, meaning that they are locked and entry and exit of patients is controlled. Staffing levels are usually higher than on an acute inpatient ward, usually multi-disciplinary and sometimes with 1:1 nursing staffing ratios. They usually receive patients who cannot be managed on the acute inpatient wards due to the level of risk the patient poses to themselves or to others. In some cases patients may also be referred from prisons or rehabilitation wards. Patients will usually be detained under the Mental Health Act.

The national guidance makes clear that the care and treatment offered in a PICU must be patient centred, multi-disciplinary, intensive, comprehensive and collaborative.<sup>3</sup> The patient's length of stay is normally short (ranging from a few days to a few weeks, depending on the patient's needs) and patients are usually returned to the acute inpatient ward as soon their risk has reduced and the more intensive treatment has started.

Our definition is provided from the national minimum standards for general adult services in PICU and low secure environments.<sup>4</sup>

Psychiatric intensive care is for compulsorily detained patients of adult working age who are in an acutely disturbed phase of a serious mental disorder. The admission for PICUs is usually due to a new episode or to an acute exacerbation of the patient's existing condition. There is often a corresponding increase in risk to themselves or others, which does not enable their safe, therapeutic management and treatment in an acute ward.

Psychiatric intensive care should be delivered by multi-disciplinary senior qualified staff and supported by effective risk assessment and management tools.

**'Psychiatric intensive care is for compulsorily detained patients of adult working age who are in an acutely disturbed phase of a serious mental disorder.'**

# Forensic services

Forensic mental health services include high, medium and low secure inpatient care as well as community and outpatient services. For the purpose of this work, only inpatient services are covered. Patients in secure care will be detained under the Mental Health Act and in many cases may have committed an offence.

This work has sought to identify existing definitions for low and medium secure services. It is important to place this in the context of wider work being undertaken to examine the patient pathway for secure services and how improvements might be made to the existing entry and exit routes for patients that might flow from that work.

## Low secure services

Low secure services for adults are provided for those patients who have long-standing and complex problems and cannot be safely or successfully cared for in acute inpatient wards. These patients are usually detained under the Mental Health Act and present a level of risk greater than general mental health services could safely address. Staff working in these settings will have experience in the provision of forensic or rehabilitation services and secure care.<sup>5</sup>

Access to this service is typically from local mental health services (including PICU), from medium secure services or from the criminal justice system.

Our definition is provided from the national minimum standards for general adult services in PICU and low secure environments.<sup>6</sup>

Low secure units deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff for patients who demonstrate challenging or disturbed behaviour in the context of a serious mental disorder, usually with complex co-morbidities and who require the provision of security.

This is according to an agreed philosophy of unit operation underpinned by the principles of rehabilitation and risk management. Such units aim to provide a homely, secure environment, which has occupational and recreational opportunities and links with community facilities.

Patients will be detained under the Mental Health Act and may be restricted on legal grounds, needing rehabilitation usually for up to two years.

## Medium secure services

Medium secure services form part of an integrated care pathway<sup>7</sup> and are specifically designed to meet the needs of adults with a serious mental illness, who require care and treatment in a secure setting to ensure they are safely managed. In most cases, patients in medium security will have committed an offence and present a serious risk to themselves or others, combined with the potential to abscond.<sup>8</sup>

Most patients enter medium secure care from court, although some may be referred from general mental health services. All will be detained under the Mental Health Act. They may also move to medium secure services by means of transfer from low to high secure services, as a consequence of changing needs. The average length of stay in medium secure care is 18–24 months, although some may require medium security for longer.<sup>9</sup>

Medium secure services provide inpatient treatment and care for adults with complex mental health problems who have been in contact with the criminal justice system and who present serious risk to themselves or others, combined with the potential to abscond. They provide a level of security suitable for public protection. Access to medium secure services normally follows a court appearance, referral for rehabilitation, PICU or from general mental health services, or transfer from high secure care.

# Recovery and rehabilitation services

There is currently no nationally agreed service specification for psychiatric rehabilitation.<sup>10</sup> The most up-to-date definition of rehabilitation in mental health is cited in *Enabling recovery for people with complex mental health needs – a template for rehabilitation services*, and is based on a national survey undertaken in 2004. This describes rehabilitation as:

**“A whole systems approach to recovery from mental illness that maximises an individual’s quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support.”<sup>11</sup>**

Rehabilitation units are provided for adults with severe and enduring mental health problems who have ongoing symptoms and functional impairments and cannot manage independent community living, even with support. At any time, around 1 per cent of people with schizophrenia receive inpatient rehabilitation.<sup>12</sup> Delayed recovery may be due to treatment resistance, cognitive impairment, severe negative symptoms, co-morbid physical long-term conditions (such as diabetes, COPD) substance misuse and challenging behaviours.<sup>13</sup>

This is a relatively small group but, with such complex mental health needs and lengthy admissions, associated costs are high. There is good evidence that with suitable rehabilitation even those with the most challenging needs progress to supported community living.<sup>14</sup>

Rehabilitation involves comprehensive assessment and individualised programmes of interventions that aim to stabilise symptoms and improve everyday functioning. These interventions include: optimising medication regimes and minimising side effects; psychological interventions to manage active psychotic symptoms, gain insight and avoid relapse, and support family/carer involvement.

They may also include specialist therapies to address ongoing substance misuse; occupational therapy to support the person to gain confidence and skills in activities of daily living and to engage in community-based leisure and vocational activities. A rehabilitation unit should have a culture of therapeutic optimism.<sup>15</sup>

Almost all NHS trusts in England provide generic rehabilitation services. Around 60 per cent are provided in a community setting and 40 per cent are hospital based. These units accept referrals direct from acute admission wards and occasionally from secure services. The aim of treatment is to develop skills for a successful return to community living with appropriate support. Community-based units provide a more homely environment than hospital-based units and usually support clients to carry out domestic tasks, whereas these tasks are performed for clients in hospital units. The average size is 14 beds and the usual length of stay is one to two years.

**‘There is good evidence that with suitable rehabilitation even those with the most challenging needs progress to supported community living.’**

### High dependency rehabilitation units

These provide rehabilitation to clients with active symptoms, more complex needs and challenging behaviours. Such units are hospital based and accept referrals from acute admission wards, PICUs and secure services. The usual aim of treatment is to move on to other facilities in the rehabilitation service prior to independent/supported community living.

Domestic services are provided by the unit. Such units are higher staffed than generic rehabilitation units and often have locked/lockable doors to manage behavioural disturbance. These units should be available in all trusts serving a population of between around 600,000 and one million. They have a major role in repatriating patients from secure services and out-of-area placements. The average size is 14 beds and the usual length of stay is one to two years.<sup>16</sup>

### Longer-term complex care/continuing care units

These provide for patients with high levels of disability who have limited potential for future improvement and continue to pose significant risk to their own health or safety, or to that of others. Co-morbidity with serious physical health problems is common, requiring on-going monitoring and treatment.

Such units can be community or hospital based and domestic services are provided. These units should be available in all trusts serving a population of between around 600,000 and one million. We do not have data on the average size nationally, but one trust reported 20 beds with an average length of stay of over five years.<sup>17</sup>

# CAMHS Tier 4 inpatient services

Child and Adolescent Mental Health Services (CAMHS) inpatient services usually fall within what are also known as Tier 4 services. These are services defined as highly specialised provision that may be required by children and young people.<sup>18</sup> Tier 4 was broadly seen as an inpatient service suitable for treating young people with the most complex needs.

Tier 4 has more recently come to be understood as multi-faceted, encompassing other elements<sup>19</sup>, but inpatient provision remains at the heart of this set of services within the four-tiered framework.

Children and young people who require admission to hospital for mental healthcare must have access to appropriate care in an environment suited to their age and development.<sup>20</sup>

An inpatient CAMHS unit would normally be the preferred environment for someone under 18 years of age<sup>21</sup>, requiring inpatient treatment and care. Admission to a CAMHS inpatient unit will usually be considered when the level of risk, complexity and/or severity of mental health need cannot be safely or appropriately managed in a community setting.<sup>22</sup> The individualised assessment and intensive educational input possible within the inpatient unit can make a major impact with young people.<sup>23</sup>

A CAMHS inpatient unit provides care and treatment for children and young people below the age of 18. Patients may or may not be detained under the Mental Health Act. Inpatient treatment is generally offered when outpatient care has been unsuccessful or when the difficulties are so severe that the family is unable to manage at home or cope at a particular time.<sup>24</sup>

Such a definition makes the specific exclusion of the following services:

- wards for adults and older adults
- any wards or beds allocated for very specialist functions (i.e. excluding eating disorder beds, learning disability beds and so on)
- any forensic medium, low secure or PICU wards
- any wards specifically designated for rehabilitation
- crisis house beds
- community-based services for children and young people, including early intervention in psychosis teams.

# Dementia assessment

The term dementia is used to describe a syndrome that may be caused by a number of illnesses with a progressive decline in multiple areas of function, including impairment of memory, reasoning, communication skills and the ability to carry out daily activities.

As well as memory impairment, dementia might also include behavioural and psychological symptoms such as depression, psychosis, aggression and wandering. These can cause problems in themselves, can complicate care giving and can occur at any stage of the illness.<sup>25</sup>

The majority of assessment and treatment for people with dementia should ideally be provided in the community and not require a 'dementia bed'. However, in some cases an assessment in hospital is necessary.

A 'dementia bed' is a bed for a patient with a presumed or confirmed diagnosis of dementia who is presenting with severe behaviours that require assessment in a hospital setting. The design of the setting should have paid due regard to the needs of those with dementia and included appropriate use of assistive technology.

Most patients in this setting will need an assessment of their capacity to consent to treatment, while consideration will need to be given to using the Mental Capacity Act, or most likely the Mental Health Act, to facilitate the admission and the treatment and management regime.

The team providing care should be multi-professional and the interventions delivered will usually be a combination of behavioural, psychological and pharmacological to manage both the impairment of memory and the challenging behaviour and other symptoms often exhibited.

Such a bed should ideally be supported by a multi-professional admission avoidance and facilitated discharge team.<sup>26</sup>

**'The majority of assessment and treatment for people with dementia should ideally be provided in the community and not require a 'dementia bed'.'**

# Care homes and nursing home care

Care homes are defined under chapter 14, section 3 of the Care Standards Act 2000. It defines a care home as any home that provides accommodation together with nursing or personal care for any person who is or has been ill, including mental illness. They might also be physically disabled or have a past or present dependence on drugs or alcohol.<sup>27</sup>

Personal care in the context of care homes includes assistance with bodily functions where such assistance is required. This may include, for instance, assistance with bathing, dressing and eating. This means that an establishment is not defined as a care home unless that type of assistance is provided where required.

Subsection (3) of the Act excludes NHS hospitals and private hospitals and clinics, including establishments that receive patients, liable to be detained under the Mental Health Act 1983, and gives the appropriate government minister the power to make other exceptions in regulations.<sup>28</sup>

Care homes that take patients on section 17 leave under the Mental Health Act, but do not take detained patients, will need to be registered as a care home rather than a hospital. Some care homes are registered to meet a specific care need, such as dementia.

**'Personal care in the context of care homes includes assistance with bodily functions where such assistance is required.'**

# Housing and housing-related support

Supporting People (SP) funds have been used to fund a range of services often referred to as housing and housing-related support. This can range from high-intensity supported housing to low-intensity floating support, to the provision of housing advice and options for future accommodation.

Three broad types of housing support service have emerged and were described as follows by York University in its report on the effectiveness of such models in March 2011.

## Staircase models

These use a series of shared residential stages to progress people with mental health problems towards independent living. The number of stages can vary, but each successive stage offers less support, with the intention that moving up a series of 'steps' will eventually lead to an independent life.

## Accommodation-based services

These are most usually a one-stage model comprising purpose-built, supported housing with onsite staffing. It is usually intended as a halfway point between institutional care and eventual resettlement into general housing. These services tended to offer individual rooms and/or self-contained studio flats.<sup>29</sup>

## Floating support services

Mobile support workers assist the transition to living independently in general housing from institutional settings and/or prevent issues linked to support needs from posing any threat to housing stability and tenancy sustainment.<sup>30</sup>

These types of housing and housing-related support services are largely delivered by housing associations in the voluntary and independent sectors.<sup>31</sup> From 2011/12, all SP funding has been rolled into formula grant (the aggregate of revenue support grant plus income from redistributed business rates, national non-domestic rates plus police grant)<sup>32</sup> and allocated via the local government finance report. This means that there are no local allocations for SP funding.

# Crisis accommodation

Crisis accommodation, sometimes referred to as a crisis house, is accommodation with support provision for people who find themselves in significant mental distress and crisis.

A crisis house is generally used as a community-based alternative to hospital admission. It usually provides support and respite from the person's usual place of residence. In some cases it may provide 24-hour cover.

It will often have in-reach from local NHS-provided crisis resolution and home treatment teams. It is intentionally designed to be a temporary place to reside and may sometimes be a form of respite. It is intended to form part of the pathway to more permanent accommodation as part of a person's recovery.

**'Crisis accommodation is intentionally designed to be a temporary place to reside and may sometimes be a form of respite.'**

# Living at home with a care package

The Care Quality Commission, in accordance with Section 20 of the Health and Social Care Act 2008, regulates organisations that provide care packages for people in the community.

NHS trusts, primary care, local authority adult social services, local authority children's services and a range of independent and voluntary sector agencies provide care packages.

A care package may include services that provide care for people living in their own homes. The needs of people using the services may vary greatly, but packages of care are designed to meet individual circumstances. The person is usually visited at various times of the day or, in some cases, care is provided over a full 24-hour period. Where care is provided intermittently throughout the day, the person may live independently of any continuous support or care between the visits.<sup>33</sup>

A care package may also include a range of care, treatment and support provided by statutory mental health services, including a range of community-based teams such as community mental health teams, assertive outreach teams, crisis resolution and home treatment teams and early intervention in psychosis teams.

A care package consists of those services provided to meet the assessed needs of the person, as recorded in their Care Programme Approach (CPA) or care plan (if they are not subject to CPA).<sup>34</sup>

Services provided by local councils are means tested and service users may have to pay for them or contribute towards their cost. They will be exempt from payment if their care package is being delivered under the terms of section 117 of the Mental Health Act.

Section 117 applies to any service user who has been detained under sections 3, 37, 47 or 48 of the Mental Health Act. It imposes a duty on health and social services to provide aftercare services to people who have been detained under the Act.

Personalisation has emerged as a way of empowering individuals to make their own informed decisions about how they want to live their lives and the help they need to do so. This represents a significant shift away from traditional models for commissioning and delivery of health and social care packages. It requires a significant transformation of health and social care so that all systems, processes, staff and services are geared to put people first.<sup>35</sup>

Personal health budgets are now being piloted across England. A recent publication by the Mental Health Network of the NHS Confederation reported that although the frustrations people currently feel with their care – lack of involvement, poor coordination and over-medicalisation – match many of the things personal health budgets are meant to improve, there is scepticism over how effective personal health budgets can be in challenging established clinical and organisational cultures.<sup>36</sup>

The development and delivery of a care package at home will now require consideration by all agencies of the impact of personalisation.<sup>37</sup>

# Recommendations for further action

Following the completion of this second phase of work, the following recommendations are offered in order to take forward practical action to implement the definitions and collect information about their use.

- This paper should be circulated to relevant clinical and managerial and commissioning networks to stimulate wider discussion.
  - This paper and the issues it explores should be discussed with colleagues at the Audit Commission as part of the benchmarking club for trusts, and discussed with the NHS Information Centre to support them in considering revising their singular definitions of inpatient and community-based services.
  - The use of the definitions in local services should be piloted over a three-month period in collaboration with the NHS Information Centre.
  - A summary report of that pilot should be produced, seeking to guide the updating of data collections. There is particular potential to explore whether data captured via the Mental Health Minimum Dataset (MHMDS) and Hospital Episode Statistics (HES) can be used.
  - In order to do this, work is needed to agree a simple set of codes which could be used to identify different bed types where (admission/ continuing inpatient stay) is recorded on the MHMDS. The NHS Information Centre (NHS IC) can liaise with working group members to report on the feasibility and process required to implement these codes on the MHMDS.
- Engagement with the stakeholders including DH, the NHS Institute, SHA mental health leads, the Audit Commission and The Association of Directors of Adult Social Services (ADASS) to establish whether their work programme might include dissemination of the definitions to commissioners with a call to action to encourage use of common definitions.

For more information on the issues raised in this report, please contact [steve.shrubb@nhsconfed.org](mailto:steve.shrubb@nhsconfed.org)

# Further reading

*Efficiency in mental health services – supporting improvements in the acute care pathway.* NHS Confederation briefing issue 214, February 2011. Available at [www.nhsconfed.org/publications](http://www.nhsconfed.org/publications)

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## Acknowledgements

This report was written by Steve Appleton at Contact Consulting.

# Defining mental health services

Health and social care commissioners and service providers are focusing on the importance of quality and productivity as ways of ensuring better outcomes, improved service models and effective interventions. Doing this requires a clearer understanding of the types of services currently provided, an understanding that is shared across the system. In mental health there has not been a consistent set of definitions that describe what is meant by an inpatient bed. This has led to difficulty in benchmarking and understanding patterns of performance.

This report seeks to address those variations of understanding by suggesting a range of definitions that can be used by commissioners and service providers.

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