# Adult acute psychiatric care in England

Did you hear that? It was a significant sigh of relief exuding from the President’s office at the RCPsych HQ, as I put down my copy of Lord Nigel Crisp’s final report on adult acute psychiatric care. Following a series of horror stories from colleagues and in the press about patients being sent all over the country for a bed - and my own experience of clinical meetings increasingly being about getting people out of beds to free the space up rather than it being in the patients’ best interests - in 2014 I asked Lord Crisp to set up an independent Commission to examine the problem and point the way forward. Now, setting up an independent Commission sounds like a great idea. These days everything has to be independent and transparent, just like every talk has to be inspirational and passionate. But then you remember that genuine independence – and if you have ever met Nigel Crisp you know that is what you are getting – also means the risk that they might not agree with you. When I started as President, I was interviewed about what I wanted to do over the next three years. I mentioned stroking lots of white cats, developing a cruel laugh and taking over the world, but then said seriously that I didn’t want to do anything that my successor would have to apologise for. And now I was having nightmares that the Commission I’d set up, and the RCPsych had paid for, would recommend that the speciality of psychiatry should be disbanded, or words to that effect.

So was I right to worry? As you’ll have guessed from the opening sentence, no. Nigel Crisp used to run the NHS in those halcyon pre Lansley days when someone could run it, and it shows. His report on acute adult care in England is thorough, evidence-based and above all sensible. It has deftly avoided the trap of just rehearsing the problems that we know are out there (the increase in out of area treatments being probably the most visible example, although as the report notes we’ve ludicrously had to rely on Freedom of Information requests to get numbers on this until very recently) and makes recommendations that are neither patronising nor platitudinous. Moreover, it sets out a practical approach to making improvements.

So what are these recommendations? Well, I want you to read the report for yourself so instead of copying them out verbatim I’ll just tell you about a few of the things which aren’t explicit recommendations but which I genuinely like about the report to whet your appetite. A few of the recommendations might sneak in, but you really should read the full report for yourself.

When myself, Laurence Mynors Wallis and the policy team at the College were putting together the brief and terms of reference for Lord Crisp to lead the Commission, we were internally referring to it as the ‘Beds Commission’ - reflecting the fact that pressures on beds were very much the face of the problem. Like many people, I confess that I thought that the easy solution was simply more beds. And in many places, the Commission agrees that is exactly what is needed. However, the strength of the Commission’s report comes in its approach of looking beyond the immediate symptoms and obvious solutions to the problem. So when the Commission surveyed consultants in charge of adult wards in England, it didn’t just ask the easy question of whether there were or were not enough beds in the area - it also asked if there would be enough beds if improvements were made in other services. And although 38% said that there were not enough beds, a whopping 28% said they would have enough beds if other improvements were made. The survey complemented this by asking how many patients on each ward could have been treated by another service (16% on average) or were clinically well enough to be discharged but could not be for some reason (unavailable housing, lack of CMHT capacity etc. - again, 16%). So yes, many places do need more beds - but in some of these places, they might only need them in the short-term while they sort other elements of the pathway out.

One of the things that I like about the report is its balanced approach. It’s all too easy with something like this to point to the bad practice (of which there is too much), with the best intentions that this will catch peoples’ eyes and they will be motivated to do something. Well, there is lots of truth to this - being confronted with the unacceptable can precipitate change in ‘poor’ services. No one goes into psychiatry to do a bad job. But when those example of poor care become the only ones talked about, after a while morale and motivation drop everywhere. Everybody feels under the cosh. After all, no matter how many times a CQC inspection reports something good, how often does the press cover that? Answer – never. And hence everybody feels depressed and harassed. And then - as Lord Crisp’s report notes - patient care begins to suffer as a result. The Commission’s report certainly shines a spotlight on unacceptable care, but is careful to celebrate examples of where Trusts, services and clinicians are innovating, providing excellent care and - in the words of patients themselves - saving lives. This is really important. I’m delighted to see it, write about it, talk about it and for journalists to report it. Which I am betting they won’t.

The last thing that I’m going to highlight about the report is its underlying principle that patients with mental health problems should have the same levels of access to high-quality care as patients with physical health problems - or to use the political vernacular, ‘parity of esteem’. This approach is helpful; it’s straightforward enough to say - as many have - that people who need acute mental healthcare should not be travelling hundreds of miles for non-specialist care, as this would never be accepted for physical care. But then you get to the sticky issue of how far is reasonable. The rural/urban distinctions between Trusts mean that just setting the Trust’s boundary for the limit of reasonableness doesn’t necessarily work. The Commission has been clever about this. Not surprising because it’s not just Nigel who is smart and experienced – we persuaded an extraordinarily talented bunch of people to give of their time for this. Take a look at the list – it’s impressive. Anyway, what they done is instead of setting a universal distance or time limit, they have concluded that that the starting point for a reasonable distance to travel for acute mental healthcare in a particular Trust is the distance that a person would expect to travel for comparable physical acute care in that Trust. This acknowledges that people typically do travel further for acute physical healthcare in rural areas, because the population is more dispersed. You can’t have a service on everyone’s doorstep. The Commission have also recommended a four-hour maximum waiting time target for admission to an inpatient unit or the commencement of home-based treatment (whichever is appropriate) in an emergency, with obvious parallels to the A&E four-hour target. Again, this seems sensible.

I’m deeply grateful to Lord Crisp , the fourteen Commissioners who most ably assisted him, and Greg Smith, Krista Nicholson and the policy team here at RCPsych who provided the support for the entire enterprise, for undertaking this piece of work on the College’s behalf. I say this very rarely, but I think this report could actually make a difference. And if you’re a general adult psychiatrist in England, then here’s where you come in, as so much of what is in the report is going to rely on you to be implemented. When your Trust Board (hopefully) read the report and say ‘let’s see how many of our inpatients are at the wrong level of care’ or ‘are our patients actually getting care in line with NICE guidelines?’ it will be you that gets the phone call to find out. Please step up to the plate. And if you don’t, there’s plenty of material in the report that you can use to make the case for change to them, or put into practice yourself. As I sign off, I’m casting my mind back to when I said that I didn’t want to do anything as President that I’d have to apologise to my successor for. If you want your successor to thank you, then [**give this report a read**](http://www.caapc.info/#!publications/cgbd) and use it to make things better.

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