**Happy Birthday to the Crisp Commission on Beds, sorry, the Independent Commission on Acute Adult Psychiatric Care, CAAPC**

**What you can do to bring about its findings and why you should.**

Anniversaries are great. Excuse for a party. An excuse for attention. Also an occasion to review work and monitor how it’s going.

We have a one-year anniversary to celebrate. One year ago the independent Commission that we set up to review the provision of acute adult psychiatric care published its findings.

Gosh, that was ponderous. Let me try again.

The Crisp Commission on Beds, as we definitely don’t call it but let’s be honest that’s what it was all about, hit headlines a year ago. I hit local radio (“Good morning Professor, this is Radio Three Rivers, please let the people of LoamShire know what your report means for them, before the traffic news”). Lord Crisp, who ran the NHS and is still a Big Cheese and thoroughly decent bloke, did the top billing on the Today Programme. He scored a blinder when John Humphrys tried to change the subject, only to be firmly put in his place: “No, this is what always happens when we talk about mental health – you try and change the subject”. Blissful.

OK, what did it conclude?[i] A lot, all on how to improve access to and quality of acute mental health care, as [you can see here](http://www.rcpsych.ac.uk/pdf/Old_Problems_New_Solutions_CAAPC_Report_England.pdf))

And what has happened since? Again, a lot - [you can find our progress report here](http://www.rcpsych.ac.uk/policyandparliamentary/commission.aspx) - and we expect even more to come, with a formal response to the report from the central NHS bodies expected to land on our desks in the next few months.

For those with short attention spans here are some of the Commission’s key recommendations and the progress made so far towards their implementation:

* **Recommendation: Out-of-area-placements (OAPs) to be eliminated**
**Progress:** The Government has committed to eliminating OAPs by 2020/21. A national definition of OAPs has been agreed at long last and national data is now collected.
* **Recommendation: Introducing four-hour waiting time targets for access to acute mental health care**
**Progress:** An evidence based treatment pathway (our favourite sort) for acute mental health care is currently being developed and will be published this Spring, including clear recommended response times and quality guidelines and benchmarks.
* **Recommendation: Ensuring Crisis Resolution and Home Treatment Teams (CRHTs) are well enough resourced to offer alternatives to inpatient admissions
Progress:** More that £400m for CRHTs will be introduced over 4 years from April 2017.
* **Recommendation: Better collection and availability of mental health data and transparency around funding**
**Progress:** More dataset changes will be implemented this Spring to provide more robust information on acute care services including use of different types of bed and delayed transfers of care.

But those of you who haven’t retired, left the country or joined a quango, must have noticed that despite this progress pressures upon acute adult services have not disappeared.

One of the most visible symptoms of this is out-of-area placements, where unwell patients have to travel long distances for care due to lack of local beds or appropriate care in the community. Last December more than 500 patients still had to travel out of area to receive care.

Don’t despair. Skilful footwork meant that we got many of our recommendations incorporated in the Five Year Forward View for Mental Health, which has been accepted by NHS England (Five Year Forward Views are all the rage at the moment, and if you haven't got one you are not just at the back of the class, you are outside the school gates pressing your nose against the bars). This means that the implementation of these recommendations really will be pushed with support of central bods, or at least they should if we continue to keep our beady eyes peeled.

But it’s not all about government, NHS England and a jumble of quangos. Frontline efforts are equally important when it comes to changing things and stopping OAPs. And that means you. So what you can do?

* [**You can start by watching a terribly clever video we have put together**](http://www.rcpsych.ac.uk/policyandparliamentary/commission/oldproblems-newsolutions.aspx)**.**

And for those who still have a sentimental liking for the printed word, read on. I do apologise if unacceptable levels of NHS jargon slip in

**1. Achieving the right balance of provision between inpatient and community care**

As the Commission stated, the solution to pressures in adult acute care is not necessarily more beds. Sometimes it is, sometimes it isn’t. Delivering accessible, high-quality care requires sufficient local beds but is also reliant on sufficient alternatives to admissions, including crisis resolution and home treatment teams, rehabilitation services, community mental health services and supported accommodation.

Robust service capacity assessments are crucial for determining care needs, eliminating OAPS, reducing waiting times, and high-quality assessments. Good models of service capacity assessment are already used by many Trusts across the country. Now is time to do this systematically.

You can help your local area deliver the right balance between the different elements of the acute pathway by encouraging your Trust to undertake a service capacity assessment with commissioners, and to act on this.

Once capacity is assessed, encourage your Trust to undertake a quality assessment. The [College Centre for Quality Improvement](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement.aspx) (CCQI) is developing a scheme to allow your areas to self-assess against access and quality guidelines. These guidelines – developed by our own [National Collaborating Centre for Mental Health](http://www.rcpsych.ac.uk/workinpsychiatry/nccmh.aspx) (NCCMH) for NHS England and NICE - will be published this year and recommend a four-hour standard for accessing acute care. Exactly what the Crisp Commission recommended. What a coincidence.

**2. Improving services through better data**

As psychiatrists, we spend hours inputting data and can be disheartened if they are not well used. Nonetheless, better data is essential to improving services and accountability. As mental health has long lagged behind physical health data this is doubly important. I have bored for England on this before.

But before you yawn, remember - robust data is a Good Thing. It can be used to hold commissioners and providers to account. We can tell when they are being naughty, not eliminating OAPs, or implementing guidelines and benchmarks. And Lord be Praised, the data we need to torment and chastise them will be available from April. And we sure will torment and chastise.

You can help. Please encourage your Trust to: (1) submit OAP data monthly; and (2) return data to the Mental Health Services Data Set (MHSDS) which will be annually reviewed to ensure information is fed back to you in a way that makes sense.

This will mean a bit of your time. So whilst you are at it, continue to encourage your Trust to implement streamlined IT systems. Some do, some don’t. Those that do make your life easier.

**3. Revolutionising ways of working through Quality Improvement**

While you might be familiar with clinical audits and peer reviews, it’s less likely that organisational Quality Improvement (QI) approaches are part of your team’s day-to-day. QI techniques can revolutionise ways of working and help reduce bed occupancy, length of stay, OAPs, sickness absence and patient complaints.

This is why the College is supporting development of QI knowledge and skills amongst members, mapping learning needs, setting up a network and ensuring QI is embedded in the curriculum of future psychiatrists. Pedanticus may point out that QI seems very similar to “clinical audit cycles”, and Pedanticus might have a point. But for a thing to keep happening, it has to change its name once in a while. Remember, “standing still is not an option” even if it’s the right thing to do.[ii]

Again, you can lead by highlighting to your Trust the importance of implementing a system-wide approach to QI and setting up QI training for inpatient staff. Your Trust can work with commissioners and clinical networks to share good practice which other areas less fortunate than ourselves (your neighbouring service, not your own of course) can learn from.

You may find it hard to believe, but psychiatrists, indeed all doctors remain incredibly important in bringing change. One mental health CEO recently said to me – “I am not a great fan of doctors, but if you want change, you have to bring the doctors with you, or it won’t happen”. Most CEOs really do like us – they wish we got more involved in these issues, not less. Like it or not, as leaders within your local services, you are well-placed to spot triggers for action, and to take action. By doing so, you will play your part in bringing about the changes suggested by the Crisp Commission on Beds, sorry, the Commission on Acute Adult Psychiatric Care. And then we will invite you to the champagne second anniversary party next year.

Our [animation](http://www.rcpsych.ac.uk/policyandparliamentary/commission/oldproblems-newsolutions.aspx) to mark the report’s anniversary contains a checklist of actions you can take to improve acute care in the areas discussed above.

Further information about the progress made so far can be found on our [website](http://www.rcpsych.ac.uk/policyandparliamentary/commission.aspx).

To find out more about the Commission, visit <http://www.caapc.info/>.

Join the discussion on social media using #CAAPC.

[i] My old friend Pedanticus has popped up to remind us that:
a) the Commission didn’t cover Scotland or Wales.
b) it did cover Northern Ireland, but in a separate report and I’m afraid its first anniversary isn’t for a few months, so it doesn’t get the champagne and flowers 'til the summer.

[ii] To be fair, which I rarely am, QI isn’t quite the same as clinical audit, but I like to have a rant from time to time.

**Professor Sir Simon Wessely**