Accounts Commission for Scotland

Adult mental health services

1

BULLETIN

JANUARY 1998

Patterns of NHS service provision

The Government supports a shift from long term institutional care towards community based mental health services. Reliable information on current resources and their use is an essential pre-requisite for the effective planning for this change in service provision, but its availability is limited. The Accounts Commission has collected data, therefore, on staffing, beds and costs of adult mental health services in NHS trusts, much of which has not been previously available for comparative purposes. Our aim is to provide a picture of the use of NHS resources to aid the agencies involved in commissioning and providing adult mental health services.

Our main findings are summarised below and are expanded on in the main body of this bulletin.

- Most of the £214 million spent on adult mental health services in the NHS in Scotland remains spent on hospital provision.[1]
- Although a few trusts have made good progress in refining their costing information, the majority of trusts have inadequate financial and management information to provide a sound basis for managing changes in service delivery.
- The pace of community based service development is varied across Scotland. The biggest service gaps for adults with mental health problems are crisis services in the community and respite care.
- The availability of beds varies between trusts, and the variation is not necessarily explained by different local needs. Bed numbers may relate more to historical levels of provision rather than current needs.
- There are significant differences in the diagnoses of men and women discharged from hospital, and variation in the lengths of hospital stay for people with similar diagnoses. Clinicians and managers should make more use of this type of information to assess the numbers of beds needed locally.
- Intensive psychiatric care beds are unevenly distributed across Scotland. This means that accessibility for many people is poor. Close attention needs to be paid to the commissioning of this specialist resource as the present piecemeal development cannot meet the needs of the whole Scottish population for a service of the appropriate quality.
- There are wide variations in staffing levels between trusts, which do not appear to be wholly related to the needs of the resident populations.
- Some trusts have established good team working for community based psychiatric nurses, enabling them to introduce a range of grades according to tasks undertaken. This makes the most effective use of the resources available.
- There are significant differences in both levels of nurse staffing and the ratio of qualified to unqualified staff on psychiatric wards. For some trusts this may mean that resources could be released from wards for community development; for other trusts more investment in in-patient services may be required.

Some of the variations highlighted above reflect geographical differences, relative levels of deprivation, or different stages in the development of community based services. However, not all the variations can be explained on these grounds. The information provided in this bulletin is offered as a starting point for further investigation into resource use, and complements other recent national documents such as the Scottish Needs Assessment Programme's Mental Health Portfolio.[2]

Introduction

The way in which mental health services are delivered in Scotland has changed over the past decade. There has been a steady move away from institutional care, and a greater emphasis on community based care for people with severe and/or enduring mental health problems. Mental health is one of three priority areas for the NHS in Scotland. The Scottish Office has recently published a Framework for mental health services[3] which emphasises the need for inter-agency planning and delivery of mental health services on the basis of local assessments of need.

The Accounts Commission is undertaking a study of the planning and provision of adult mental health services by NHS trusts, health boards and local authorities. The study excludes services for elderly people, children and adolescents, and specialist provision such as forensic or drug and alcohol services. During the first year we have concentrated on NHS trusts' planning, and the collection of basic data as reported in this bulletin. Local audits were carried out in 15 of the 21 mainland NHS trusts which are major providers of adult mental health services (excluding the State Hospital). These trusts are predominantly community healthcare trusts. A report detailing local audit findings has been produced for each of these trusts, providing local analysis of the data provided here. The exhibits in this bulletin are based on the data returned by trusts. Where number of trusts vary between exhibits this reflects the fact that not all trusts provide all services.

Information on current resources is needed, together with an assessment of the needs of the population, in planning mental health services. Trusts should be collecting routinely the type of information contained within this bulletin; using it for their own internal review of services and to compare services with similar trusts. This bulletin is a contribution to the process. This year's audits will build on this information, and examine in more depth the commissioning and management of adult mental health services.

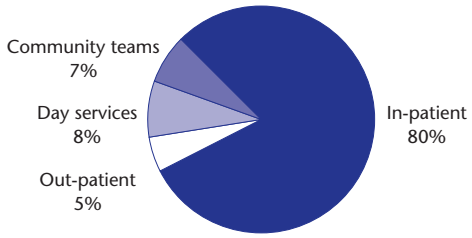
This is the first in a series of bulletins on adult mental health services. Subsequent bulletins will cover the involvement of users and carers in the planning, monitoring and evaluation of services; and the Commission's research into indicative costs of different mental health service models.

Patterns of expenditure

Around £214 million is spent on adult mental health services in the NHS in Scotland. However, the Commission's work in trusts over the past year has shown that many trusts cannot readily identify, in a meaningful way, how this money is spent. Costs for different client groups cannot always be separated, and costs are often collected on the basis of professional groups (such as psychologists) or institutions (such as hospitals). This is no basis for the effective planning of services.

Despite the closure of many long stay beds, most NHS expenditure for adult mental health services is still used for hospital provision (exhibit 1).

Exhibit 1: Breakdown of NHS expenditure on adult mental health services



Note: the expenditure on community teams is an estimate only. The way in which costs are presented does not enable a split between community team members working with adults up to 65 years and those working with elderly people or children.

Source: Scottish Health Service Costs, 1997

Nationally collected cost information does not provide a sufficiently detailed picture of resource use for planning changes in service delivery. For this reason the Commission's auditors attempted to calculate detailed, consistent service costs. Our aims were:

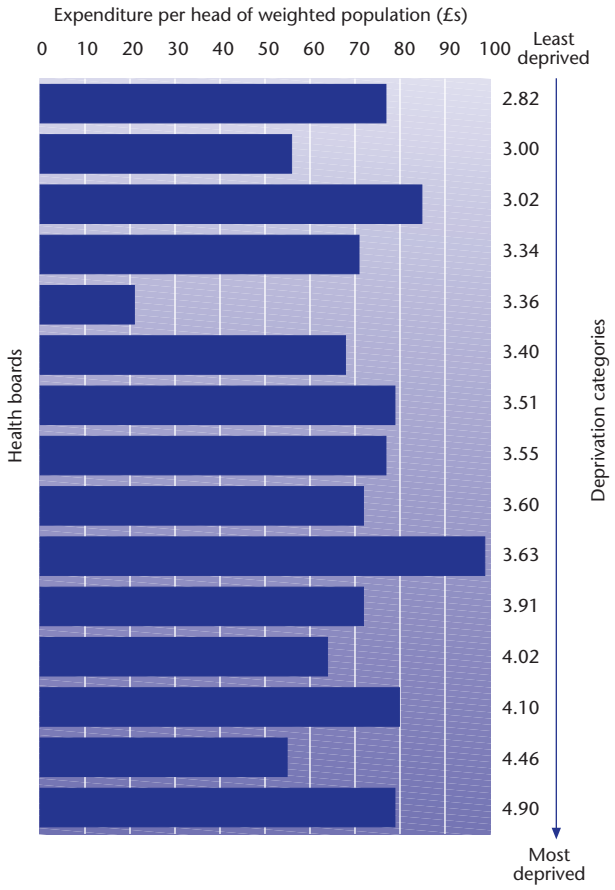
- to provide the NHS in Scotland with independently validated service costs to use in planning and managing shifts in resources
- to enable trusts to benchmark against similar trusts in order to assess value for money in the delivery of services.

However, only seven trusts had sufficiently robust financial information systems to provide the information requested. Without this information on the costs of services, it is difficult to see how, at a local or national level, the development of community services for adults with mental health problems can be achieved in a planned and managed way. Although the cost of a service is only one part of the overall planning equation - along with good needs assessment, quality and effectiveness information - it is an essential one. However, progress is being made in this area: the Priority Services Directors of Finance Benchmarking Sub-group are about to undertake a detailed costing exercise which will provide further valuable information.

The Commission will publish a further bulletin in this series, setting out the results of our research into indicative costs of different service models. This is not a substitute for the development of good local costs information; instead it will highlight how such information can be used.

There is significant variation in the level of expenditure on all mental health services between health boards. This variation does not appear to be linked to the deprivation of health board areas. This issue will be investigated as part of the audit of health boards' commissioning of adult mental health services over the coming year. Exhibit 2 shows the level of expenditure per head of population for each health board area. The boards are ordered according to the deprivation of their area with the least deprived area at the top and the most deprived area at the bottom of the graph. Deprivation scores (1-7) are calculated on the basis of a number of indicators of need. High scores are associated with high levels of deprivation.[4]

Exhibit 2: Expenditure on all mental health services by health board ordered by deprivation



Source: Scottish Health Service Costs, 1997 and Carstairs and Morris, Deprivation and health in Scotland, 1991

In-patient beds

There are wide variations in the number of beds across Scotland which are not necessarily explained by different local needs, and may relate more to historical levels of provision. There are significant differences in the diagnoses of men and women discharged from hospital, and in lengths of stay for people with similar diagnoses. Clinicians and managers should make greater use of this type of information to inform their local planning.

Beds are an expensive, but necessary, part of an adult mental health service, with £171 million spent on in-patient services in 1996/97.[5] To avoid tying up resources which could be used to develop a range of community based services it is important that beds are used effectively, and that the need for beds is assessed accurately. The number of beds needed will depend on the number of people in the area with serious mental health problems for whom hospital care is considered appropriate. It will also be influenced by the range and organisation of community services.

This assessment of the number of beds needed requires good information on the current numbers of psychiatric beds and their use. Although information is available on total psychiatric bed numbers, there has been a lack of routinely collected information on the number of adult psychiatric beds in the following categories:

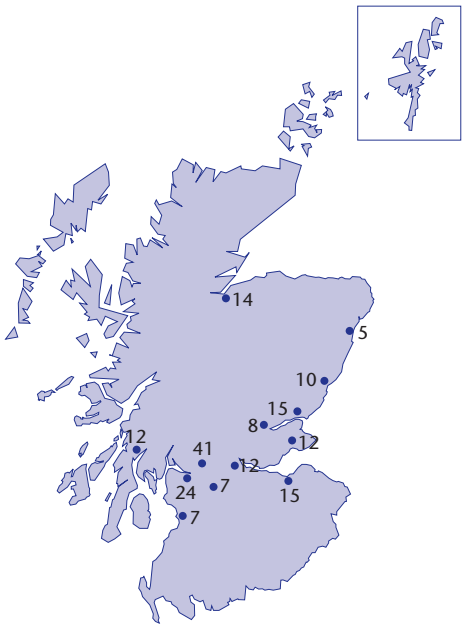
- intensive psychiatric care
- acute
- rehabilitation
- long stay.

This information is essential for planning purposes. Auditors collected information on beds broken down into the above categories as a first step in helping trusts to assess their current position.

Intensive psychiatric care beds

Less than half the trusts audited have intensive psychiatric care beds, some of which are located with forensic services. The geography of Scotland means some people will have to travel significant distances for mental health services (exhibit 3). This has implications both for the patient and for family and friends, and raises questions about equity of access and quality of care. The location of intensive psychiatric care beds is an issue which requires further review at an individual trust and health board level. In assessing this a balance needs to be struck between the patient's desire for a local service and the relatively high cost of providing a quality service. Consortia arrangements may be appropriate.

Exhibit 3: Location of intensive care beds



Source: Accounts Commission survey, 1997

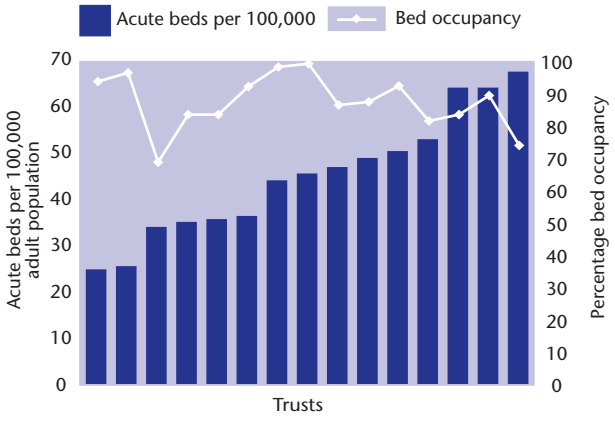
Acute beds

A review by the Scottish Needs Assessment Programme[6] acknowledges that it is unwise to be too prescriptive in terms of bed numbers, but suggests a norm of 29 beds for an average population of 100,000. This will be influenced by a number of factors, including:

- the extent to which community services have been developed
- the link between hospital and community services
- the effective use of beds.

Many trusts have more than 29 beds per 100,000 population and, as exhibit 4 shows, the number of beds are not necessarily related to occupancy levels.

Exhibit 4: Acute psychiatric beds per 100,000 adult population and bed occupancy

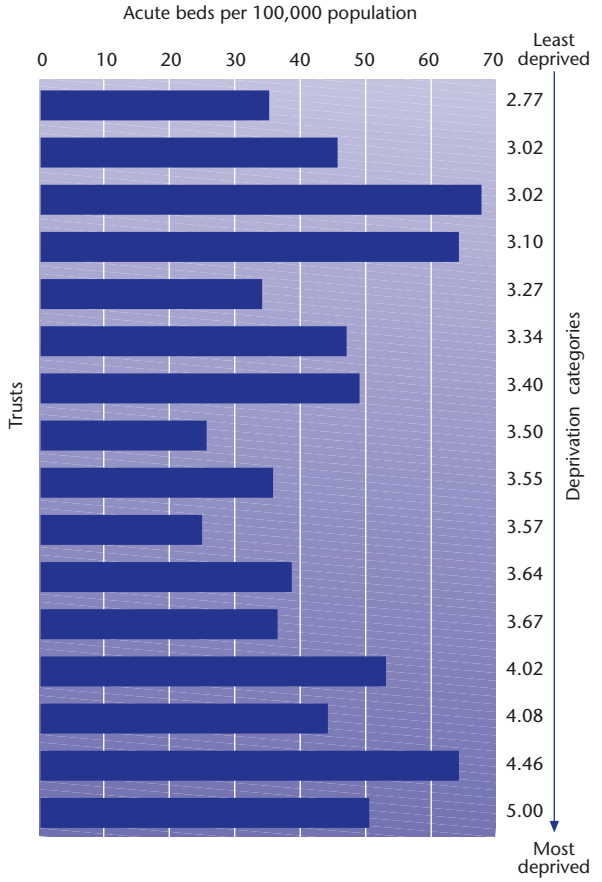


Note: two trusts requested separate analyses for their two localities.

Source: Accounts Commission survey, 1997

Also, the link between the incidence of mental health problems and the level of deprivation in an area is well documented.[7] However, the current number of acute beds per 100,000 adult population is not necessarily linked to the deprivation of the area (exhibit 5).

Exhibit 5: Relationship between deprivation score and acute beds per 100,000 adult population



Source: Accounts Commission survey, 1997

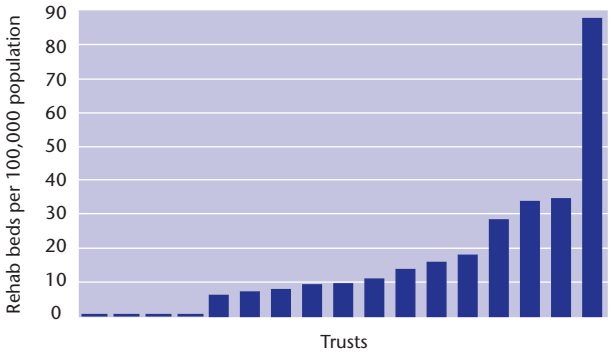
Overall, these analyses (exhibits 4 and 5) suggest that a number of trusts should review their acute bed numbers and adjust the level if necessary. This should not be done purely on the basis of bed occupancy. Consideration should also be given to:

- the number of people with serious mental health problems in the local area
- the level of deprivation
- the severity of illness of those people using hospital beds (as some people may be in hospital unnecessarily)
- lengths of stay
- quality of discharge arrangements
- community support available.

Rehabilitation beds

Rehabilitation beds, in combination with community rehabilitation services, are an important part of a comprehensive adult mental health service. They are used for people who need a high level of support in coping with discharge and independent living. In the main, rehabilitation beds are still hospital based, although some are provided in smaller domestic settings on the hospital site but separate from the main ward blocks. A minority of trusts have no rehabilitation beds. Other trusts have between three and eight rehabilitation beds per 100,000 adult population (exhibit 6). This range suggests that some trusts cannot achieve the aims of a rehabilitation service.

Exhibit 6: Hospital rehabilitation beds per 100,000 adult population



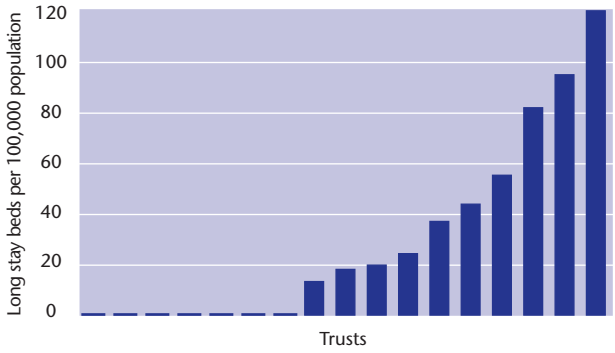
Source: Accounts Commission survey, 1997

The trust with 88 beds per 100,000 population appears to be classifying its long stay beds as rehabilitation beds. This is not merely a matter of semantics. As people in long stay institutional care move out of hospital into the community, resources will need to move with them. If they are moving from what is classified as a 'rehabilitation' bed it is less obvious that this bed is no longer needed. This classification problem may be responsible, in part, for the lack of clarity found by the Commission in our review of resource transfer from health to local authorities.[8]

Long stay beds

Despite a reduction of just over 7,500 psychiatric beds during the period 1985-95, some trusts still have a significant number of long stay beds for adults (exhibit 7). The reduction in mental illness beds is slightly overstated as it reflects in part a reclassification between general mental illness beds and psychiatric beds for elderly people.

Exhibit 7: Long stay beds per 100,000 adult population



Note: Beds for elderly people are excluded from this analysis.

Source: Accounts Commission survey, 1997

There may be a number of reasons for this variation, including the level of resources available for bed closures, different levels of deprivation putting pressure on other parts of the service, and differences in the development of community based services.

This picture of long stay bed provision also needs to be considered alongside the number of supported accommodation places for people with long term mental health problems. The closure of long stay beds and their replacement with supported accommodation and other services in the community requires a high level of inter-agency working. Thus a large number of long stay beds and few supported accommodation places may indicate weaknesses in local inter-agency planning arrangements.

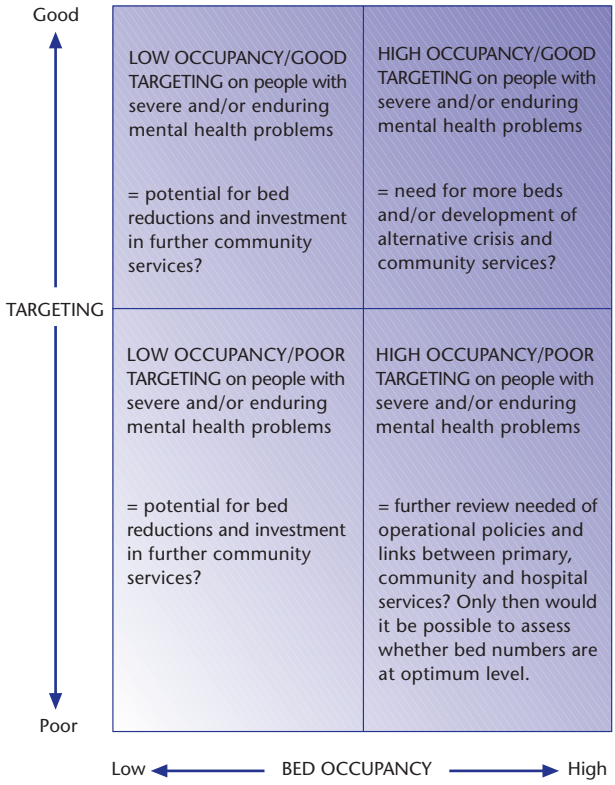
Targeting beds on people most in need

Admission to hospital can be disruptive for people, and hospital beds are an expensive resource. For these reasons hospital resources should be targeted on those people with the most severe mental health problems, and those who are considered to be most at risk. For this to work effectively, adequate community services need to be in place enabling people with less serious mental health problems to receive treatment in the community.

Research has shown that developing community services leads, at least initially, to increased pressure on acute beds as previously undetected needs are identified. In the medium to longer term, however, well developed community services may increase the number of admissions but can reduce people's lengths of stay in hospital.[9]

Bed occupancy figures alone will not give sufficient information to help assess the number of acute psychiatric beds needed to support a local adult mental health service. Instead, managers and clinicians should be using information on bed occupancy combined with the extent to which beds are being targeted on people with severe mental health problems, as described in exhibit 8.

Exhibit 8: Assessing the implications of bed occupancy and targeting services to those in most need



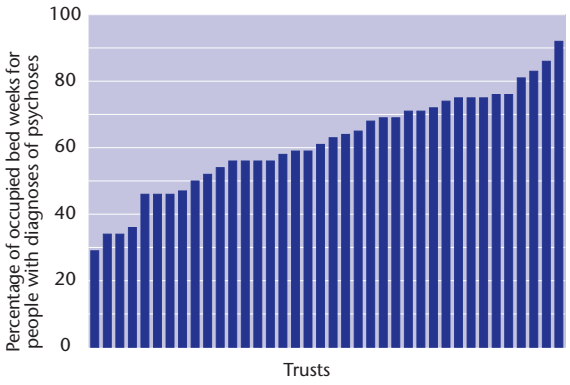
The Mental Welfare Commission for Scotland provides valuable comparative information on the number of people detained under sections of the Mental Health (Scotland) Act.[10] This is important information when considering the way in which beds are targeted on seriously ill people.

In addition, centrally collected data can be used to examine this targeting, using diagnoses of psychoses as a proxy measure for severity of illness. All trusts, which provide psychiatric in-patient services, return information on in-patient discharges on a form called the Standard Morbidity Record 4 (SMR4) to the Information and Statistics Division (ISD) of the NHS in Scotland.

During 1995/96, 40% of all discharges from adult psychiatric beds were people with diagnoses of psychoses. However, analysing the information on the diagnoses of people who have been in hospital is of only limited use in looking at the overall use of beds. In addition, we need to look at *how long* people stayed in hospital.

The proportion of occupied bed weeks accounted for by people with severe mental health problems is a better overall measure of how well targeted the in-patient service is to need (exhibit 9). If the service is well targeted, one would expect to see the greatest proportion of bed weeks used by people with the more severe mental health problems.

Exhibit 9: The proportion of occupied bed weeks used by people with severe mental health problems



Source: SMR4 data, 1995/96

As exhibit 9 shows, there is wide variation between trusts in Scotland in the extent to which beds are being used for people with severe mental health problems. This picture is very similar to that found by the Audit Commission in English and Welsh trusts. The Audit Commission estimated that, if the poorer performing trusts in England and Wales targeted beds more effectively, £100 million could be saved in hospitals for the development of community services.[11]

For Scotland, it is not yet possible to make similar estimates on the potential for releasing resources from hospital for reinvestment in community services. This is because the data are not sufficiently refined. SMR4 forms do not enable a distinction between the *type* of psychiatric bed and this could distort some of the analysis. Discharges from acute beds are grouped with those from rehabilitation and long stay beds despite there being a very different pattern in bed usage. People with the most severe mental health problems are likely to be making the most use of rehabilitation and long stay beds and staying in hospital longer (exhibit 10). People admitted to acute wards would be expected to have shorter in-patient stays than those on rehabilitation and long stay wards.

Information allowing a distinction to be made between discharges from acute, rehabilitation and long stay beds would be of value for research and clinical audit, as well as providing useful management information. The Commission recommends, therefore, that the SMR4 form is amended to ensure these data are collected. The quality of SMR4 form completion should be audited locally to ensure that the data are valid and reliable.

However, in spite of these caveats about the data, they do suggest that beds in *some* trusts are not being targeted on the most seriously ill people, and are possibly being used for people who could be treated in the community if other services were in place.

The diagnoses of patients discharged from psychiatric hospitals were further categorised into six groupings with information on lengths of stay and the percentage of overall bed weeks used by people in each group (exhibit 10). This shows that almost two-thirds of occupied bed weeks were by people with diagnoses of psychoses, although as we have already noted this could be distorted by the mix of beds. Looking only at the use of acute beds may give a different picture.

Exhibit 10: Lengths of stay by diagnostic groups in weeks

Diagnostic group	Median length of stay in weeks	Percentage of total occupied bed weeks	Inter decile range
Psychoses	3	63	< 1-15
Dementia	2	3	< 1-22
Alcohol and drug related	1	9	< 1-4
Personality	1	2	< 1-6
Neuroses	1	12	< 1-8
Other diagnoses not included in above groupings	< 1	10	< 1-6

Source: SMR4 1995/96

Note: Percentages have been rounded and thus do not total 100. Inter decile range shows the range between which 10% and 90% of cases lie. Examining this, in combination with the median value, highlights the existence of outlying values skewing the range.

As part of the Commission's continuing review of adult mental health services auditors will provide trusts with an analysis of their individual performance. Further analysis can be taken down to ward level to provide more detailed information on the use of beds. This will provide key information in helping to assess the number of beds needed to support a local adult mental health service.

Finally, the SMR4 records showed that there was a statistically different distribution of diagnoses between men and women (exhibit 11).

Exhibit 11: Diagnoses of people discharged from psychiatric hospitals, 1995/96

Diagnostic group	Males (%)	Females (%)
Dementia	171 (2)	138 (2)
Alcohol and drug related	2955 (30)	1295 (15)
Schizophrenia	2226 (23)	1115 (13)
Affective psychoses	1119 (11)	1718 (19)
Other psychoses	743 (8)	536 (6)
Personality disorders	353 (4)	442 (5)
Neuroses	1588 (16)	2858 (32)
Other diagnoses not included in above grouping	593 (6)	722 (8)
Total number =	**9748 (53)**	**8824 (47)**

Source: SMR4 1995/96
$x^2 = 1524.5$, DF = 7, $p < 0.005$

Note: ICD9 diagnostic codes were regrouped into the above categories to simplify the analysis. ISD supplied the Commission with anonymised SMR4 data for the year 1995/96. This represented the most recent complete data set available for analysis. From this we selected all records of people between 18 and 64 with a diagnosis of mental illness: 18572 records in total.

Men were significantly more likely than women to have an alcohol or drug related illness, or a diagnosis of schizophrenia. However, there were many more women with the less serious mental health problems, categorised as neuroses. This is similar to the findings of the Office of Population, Censuses and Surveys in its survey on the level of psychiatric morbidity in the population.[12] This information at a local level, combined with user feedback, would help trusts in planning for single sex wards, or alternative flexible bed options.

Staffing

There are big differences between trusts in the numbers of staff in each of the professional groups. These differences are not necessarily linked to the mental health needs of the population.

Hospital based nurses

There are significant differences in both the levels of nurse staffing and the ratio between qualified and unqualified staff on psychiatric wards. For some trusts this may mean that resources could be released from wards for community development; for other trusts more investment in their in-patient services could be required.

Comparative information on the staffing of psychiatric wards for adults, by type of ward, is not routinely available. Auditors collected information, therefore, on the grade and number of whole time equivalent (WTE) nurses in post on the following adult psychiatric wards:

- intensive psychiatric care
- acute
- rehabilitation
- long stay.

On all wards there are wide variations in the percentage of qualified staff (exhibit 12). Only two trusts have any C grade nurses; for all other trusts, qualified staff are nurses of D grade and above.

Exhibit 12: Grade mix of staff on adult psychiatric wards

Type of ward	Range of qualified nursing staff on psychiatric wards
Intensive care	53% - 78% qualified
Acute	56% - 93% qualified
Rehabilitation	48% - 100% qualified
Long stay	40% - 73% qualified

Source: Accounts Commission survey, 1997

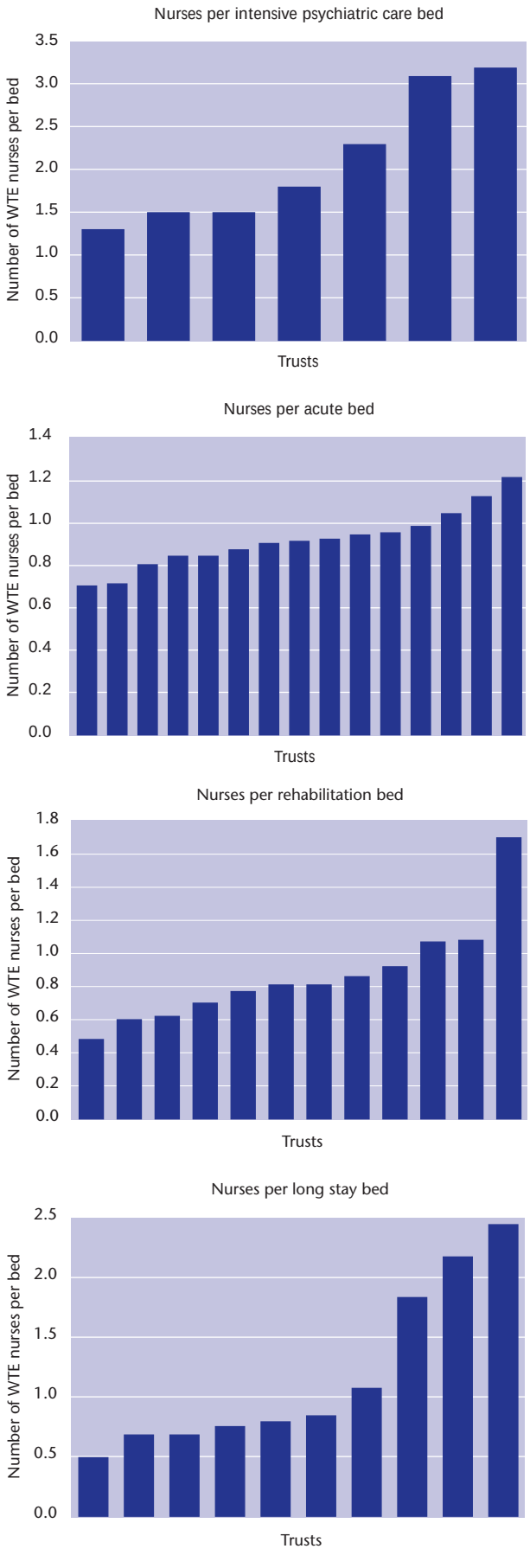
There are no national guidelines for the optimum balance between qualified and unqualified staff because the balance and number of staff needed will depend on:

- the severity of illness of in-patients
- the therapeutic input which the service is aiming to provide on wards
- the range of tasks undertaken
- the agreed quality standards between health boards and trusts.

In assessing this locally, trusts must analyse the use of beds and the types of skills needed to provide the required level of care to patients. The variation in skill mix suggests that this may not be happening in all trusts. Some trusts are making only limited use of unqualified support staff on wards; other trusts are heavily dependent on this staff group. Having reviewed the skills needed, it is important that trusts ensure all ward staff, qualified and unqualified, have the appropriate training for the required skills.

The number of nurses per available staffed bed provides a measure of relative staffing between trusts. Our findings raise serious questions about the level of staffing on some wards (exhibit 13).

Exhibit 13: Nurses per available staffed bed (by type of bed)



Source: Accounts Commission survey, 1997

The differences in ward staffing between trusts suggests that there may be different levels of interaction between staff and patients. In particular, staff on some intensive psychiatric care wards could be struggling to maintain the high level of care and observation required unless, in those facilities shared with forensic services, other nursing staff can provide further support.

The Commission's own consultation with users has shown that contact with, and support from, ward staff is something that users value when they are in hospital.[13] However, a recent visit to 309 acute psychiatric wards in England and Wales by the Sainsbury Centre for Mental Health and the Mental Health Act Commission highlighted concerns about the limited involvement of nurses with patients.[14]

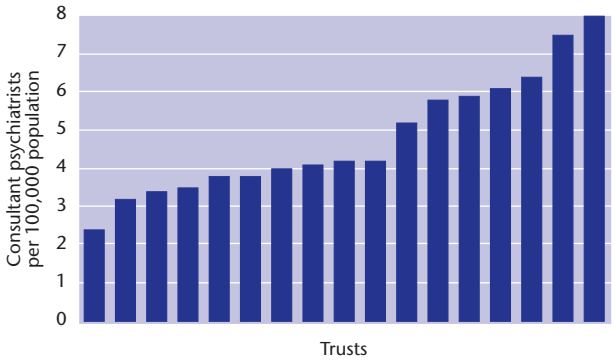
This is an area both trusts and health boards should be reviewing. Good practice guidelines from the Clinical Resources and Audit Group (CRAG) clearly state that adequate staffing levels and skill mix should be agreed between trusts and health boards, and "should be based upon analysis of workload which takes account of the requirements for nurse observation according to explicit local protocols."[15] The Commission will be reviewing the extent to which these good practice guidelines have been implemented.

The quantitative comparisons provided here should be used, in conjunction with local reports by the Scottish Health Advisory Service on the quality of care provided on wards, to review the adequacy of ward staffing arrangements.

Consultant psychiatrists

The number of consultant psychiatrists in post varies from just over two to eight psychiatrists per 100,000 adult population (exhibit 14). This picture is affected by some trusts having serious recruitment and retention difficulties and other trusts having teaching status, which more readily attracts staff. It is interesting to note that where recruitment is an issue trusts have worked hard at developing links with primary care. The trusts with above average number of psychiatrists tend to be those covering the more rural areas.

Exhibit 14: Psychiatrists per 100,000 adult population

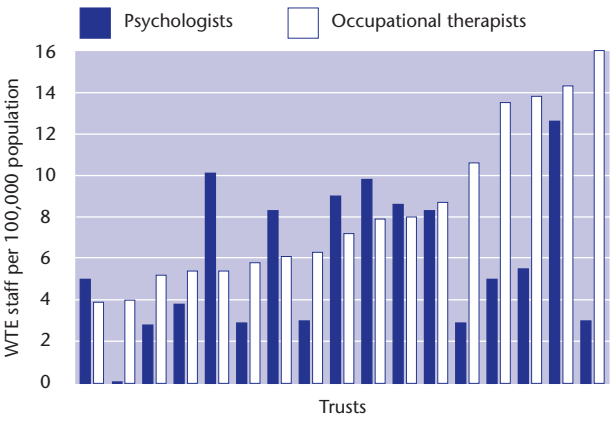


Source: Accounts Commission survey, 1997

Psychologists and occupational therapists

Psychologists and occupational therapists are important members of a multi-disciplinary mental health service, providing distinctive areas of expertise. There are wide differences between trusts in the numbers employed, with one trust having no psychologists at all (exhibit 15). This raises the issue of equity of access to their services. However, there are national shortages of both psychologists and occupational therapists which is one contributory factor to the differences between trusts.

Exhibit 15: Numbers of psychologists and occupational therapists per 100,000 adult population



Source: Accounts Commission survey, 1997

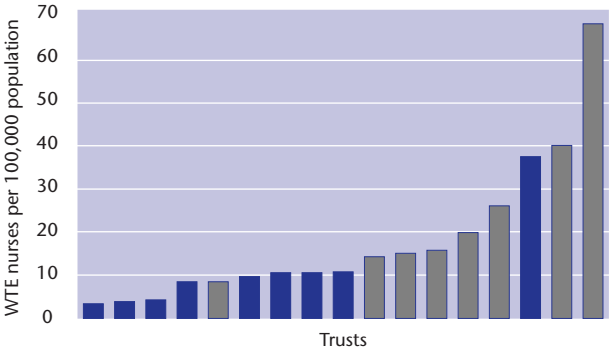
Where trusts have relatively low numbers of psychologists or occupational therapists they should be working with their respective health boards in reviewing whether this level is truly related to the needs of the population or whether it is having an adverse impact on:

- patient care
- waiting list times
- the development of multi-disciplinary community teams.

Community based psychiatric nurses

The number of community based psychiatric nurses is one indicator for the extent to which trusts are developing community services. There are big differences in the number and grade mix of community based psychiatric nurses, with some areas having a very limited service (exhibits 16 and 17).

Exhibit 16: Community based psychiatric nurses (A-G grades) per 100,000 adult population



Note: trusts marked ■ are predominantly rural.

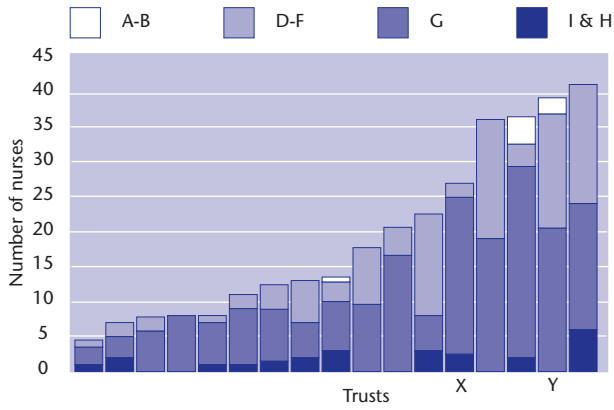
Source: Accounts Commission survey, 1997

There is a link between the number of nurses per 100,000 population and whether the trust covers rural or urban communities. Most trusts with small populations and a large geographical spread have relatively high numbers of community based nurses per 100,000 population.

Several trusts have established good team working for community based psychiatric nurses, enabling them to introduce a range of grades according to tasks undertaken (exhibit 17). This makes the most effective use of resources available: G grade nurses can concentrate on assessment, the more complex interventions and supervision, whilst lower grade nursing staff can provide the less complex, but nevertheless important and time-consuming, care.

However, some trusts appear not to have examined the grade mix of their community nursing staff. If trust X in exhibit 17 introduced the same proportional grade mix as that used by trust Y it could release £75,000 for other service developments. This is illustrative only; a trust's ability to do this would depend on the development of team working and a detailed analysis of tasks and skills needed to do the work of the team.

Exhibit 17: Grades of community based psychiatric nurses



Note: No trusts in the sample have C grade community based psychiatric nurses

Source: Accounts Commission survey, 1997

Development of community based services

The pace of community based service development is varied across Scotland. The biggest service gaps for adults with mental health problems are crisis services in the community and respite care.

NHS mental health services are only one part of any local provision. Mental health is an area where other agencies, particularly voluntary organisations, are also large service providers. The challenge for trusts is to ensure that people who use their services have access to the range of other provision available locally. It is disappointing to note, therefore, that four trusts reported no knowledge of the other mental health services in their area.

Out of hours services are provided by a third of trusts, many of which are useful extensions of existing services. A major gap remains, however, in the provision of crisis services, such as intensive home support as an alternative to hospital admission, or crisis beds in a community setting.

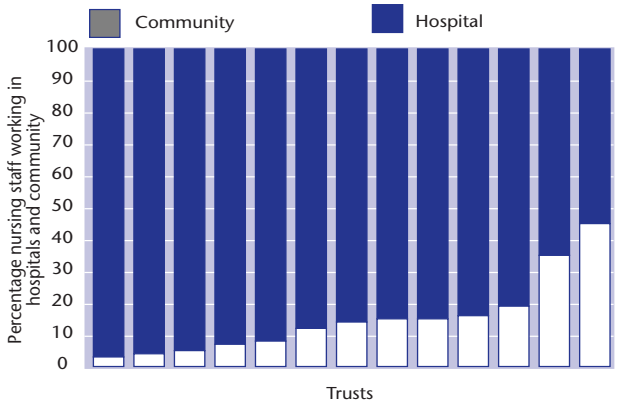
Formal respite care services, provided by the voluntary sector, are available in some cities but are not available in most other areas of Scotland. It is likely that this provision is supplemented by other informal respite services, although information was not available on these from the trusts. In the absence of local respite services, trusts sometimes use hospital beds to provide respite care but this is not a long term solution.

The development of community teams is varied across Scotland, and different team models are in evidence. Six trusts have multi-disciplinary community teams; the remaining nine trusts have community based psychiatric nursing teams. Five trusts also have separate rehabilitation nurse teams working with people with the most serious mental health problems.

The Commission's audit over the coming year will examine the management of these different teams and the way in which they are targeting people with serious mental health problems.

The proportion of a trust's total mental health nursing staff who are working in the community is one indicator of the extent to which trusts are developing community based services. Exhibit 18 shows that this picture is extremely varied across Scotland.

Exhibit 18: Relative balance of hospital and community psychiatric nurses



Source: Accounts Commission survey, 1997

Further work

The information provided in this bulletin provides a starting point for NHS trusts, health boards and their planning partners in assessing locally the level and use of NHS resources in adult mental health services.

Further work is required by the NHS to identify where resources are currently spent in order to inform service planning. For example, Greater Glasgow Community and Mental Health Services NHS Trust is examining the caseloads of its community staff and the relative levels of need in each of its community mental health resource centre areas. In this way it is aiming to provide, within existing resources, a more equitable distribution of resources based on identified local needs. This good practice could be adopted more widely.

The Commission will be undertaking further work on adult mental health services in NHS trusts, health boards and local authorities over the coming year.

Recommendations

1 Trusts and health boards should ensure that the allocation of resources is related to the needs of the population.

2 Resources should be targeted on those people with the most severe mental health problems, and those who are considered to be most at risk.

3 Trusts should use the types of information presented here for their own internal review of services and for benchmarking with similar trusts.

4 To assist in this, clinicians and managers should make more use of information on the use of hospital beds (available from a range of sources including SMR4 and the Mental Welfare Commission for Scotland's statistics) in assessing the number of beds needed locally.

5 The SMR4 form should be amended to ensure a distinction can be made between discharges from acute, rehabilitation and long stay beds. The quality of SMR4 form completion should be audited locally to ensure that the data collected are valid and reliable.

6 Trusts should implement the CRAG good practice guidelines on the nursing observation of acutely ill people in hospital.

7 Quantitative comparisons on ward staffing should be used, in conjunction with local reports by the Scottish Health Advisory Service, to review the adequacy of ward staffing arrangements.

References

1 *Scottish Health Service Costs.* Information and Statistics Division, 1997

2 *Mental Health Portfolio.* Scottish Needs Assessment Programme, 1997

3 *Framework for mental health services in Scotland.* The Scottish Office, 1997

4 *Deprivation and health in Scotland.* Carstairs, V. & Morris, R. Aberdeen University Press, 1991

5 *Scottish Health Service Costs.* Information and Statistics Division, 1997

6 *Mental health: Effects of changing patterns of service provision and their health, social and economic implications.* (Part of Mental Health Portfolio) SNAP, 1997

7 ibid

8 *Shifting the balance.* Accounts Commission, Edinburgh, 1997

9 *Commissioning mental health services.* Thornicroft G. & Strathdee G. HMSO, 1996

10 *Annual Report 1996-97.* Mental Welfare Commission for Scotland. 1997

11 *Finding a place: a review of mental health services for adults.* Audit Commission. HMSO, 1994

12 *The National Psychiatric Morbidity Survey: Household Survey.* OPCS. HMSO, 1995

13 *Report of focus groups for users of mental health services and carers.* Consultation & Involvement Trust Scotland. 1997, unpublished

14 *The national visit.* Mental Health Act Commission & Sainsbury Centre for Mental Health. 1997

15 *Nursing observation of acutely ill psychiatric patients in hospital. A good practice statement.* CRAG SCOTMEG Working Group on Mental Illness. HMSO, 1995

The Accounts Commission for Scotland

The Accounts Commission is a statutory independent body which through the audit process assists the NHS and local authorities in Scotland achieve the highest standards of financial stewardship and the economic, efficient and effective use of their resources.

The Commission has five main responsibilities:

- securing the statutory external audit
- following up issues of concern identified through the audit to ensure a satisfactory resolution
- reviewing the management arrangements which audited bodies have in place to achieve value for money
- carrying out national value for money studies to improve economy, efficiency and effectiveness in the NHS and local authorities
- issuing an annual direction to local authorities setting out the range of performance information which they have to publish.

The Commission assists the NHS in achieving value for money by highlighting good practice, providing comparative information, and supporting auditors in reviewing performance locally. Its Health and Social Work Studies Directorate is responsible for managing a national programme of value for money studies.

Acknowledgements

The Accounts Commission is grateful to all the individuals and organisations who assisted in the data collection for this study.

In particular, we thank the advisory panel who provided support and comment on this bulletin. The panel consists of representatives from trusts, health boards, the NHS Management Executive, social work departments and the voluntary sector.

If you would like more information about the study or additional copies of the bulletin please contact:

Barbara Hurst or Sara Twaddle
Health and Social Work Studies
Accounts Commission for Scotland
18 George Street
Edinburgh EH2 2QU
Telephone 0131 477 1234

Accounts Commission for Scotland

18 George Street
Edinburgh EH2 2QU
Telephone 0131 477 1234
http://www.scot-ac.gov.uk