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Better mental health in general hospitals

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Workstream 2: Development and evaluation of interface geriatrics for older people attending an AMU

Workstream 3: Development and evaluation of improvements to health care in care homes

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Better mental health in general hospitals

Summary

- Mental health problems are common in patients in general hospitals and are associated with worse outcomes than in patients without them. The quality of care for such people, especially those with dementia, is poor. The dominant theory upon which dementia care is based is a psychosocial one, "patient centred care", which is based upon Tom Kitwood's concepts of personhood and avoiding "malignant social psychology": this model has been refined to "relationship centred care" which focuses upon relationships, and other models of care designed for people with psychiatric problems exist. In contrast, to person centred care, the most commonly used theories underpinning the training of nurses tend to be task focussed.
- The behaviour disturbances seen in people with dementia are likely to be environmentally sensitive, offering an opportunity to improve care through environmental change. The literature also abounds with possible interventions in terms of therapies or practices, many of which could be applied to hospitals in the UK.
- Dementia care in general hospitals is becoming an increasingly important topic to the NHS in the UK, as evidenced by the National Dementia Strategy in 2009. A preferred service model to help meet the needs of patients with mental health problems in hospital is to use old age liaison psychiatry services, although it is unclear what such services should comprise, there is no firm evidence of cost effectiveness, and it is not clear how they would facilitate person centred care.
- Tools, such as "Dementia Care Mapping" exist to examine how care is delivered and to improve it. NHS quality improvement tools might also be employed to improve care, and there are also other approaches to improve quality of care at the organisational level, although it is not clear if these will improve person centred care. Possible mechanisms to effect change might be through commissioning, legal, or regulatory means.

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Mental health problems are common and important in general hospitals

Mental health problems are known to be common in general hospitals. This evidence has been extensively reviewed, most notably in "Who Care Wins" prepared by the Royal Collage of Psychiatrists[1]. A summary of this is:

- Older people occupy 2/3 of NHS beds
- 60% of those admitted have or develop a co-morbid mental disorder
- Mental disorder is an independent predictor of poor outcome (increased mortality, increased LOS, loss of independent function, institutionalisation, readmission, depression) and cost

The following table, drawn from Who Cares Wins, summarises the studies of the prevalence of mental health diagnoses in general hospital patients.

Diagnosis	No. of Studies	Total. no. of participants	Mean sample size	Prevalence Range	Mean Prevalence
Depression	47	14632	311	5-58%	29%
Delirium	31	9601	309	7-61%	20%
Dementia	17	3845	226	5-45%	31%
Cognitive impairment	33	13882	421	7-88%	22%
Anxiety	3	1346	449	1-34%	8%
Schizophrenia	4	1878	376	1-8%	0.4%
Alcoholism	4	1314	329	1-5%	3%

Dementia is the most common psychiatric condition in older people in hospital. One paper looking at this in detail[2] showed that 20% of elderly people admitted as a medical emergency to hospital already had a diagnosis of dementia, but a further 20% were found to have the condition through a psychiatric assessment done by the researchers whilst in hospital[2]. The UK National Dementia Strategy[3] explicitly acknowledges that general hospitals, whether they recognise or respond to this or not, admit large numbers

of older people with psychiatric conditions. Therefore acute hospitals need to deliver psychiatric care as well as the physical care with which they are more usually associated.

"Seeing the person in the patient: The Point of Care review paper" [4] reviewed the experience of patients in English hospitals as revealed by stories, surveys and complaints. The evidence was mixed: whereas national surveys generally show high levels of satisfaction, more personalized accounts revealed concerns over the quality of care such as compassion, co-ordination, information, comfort, dealing with anxiety, and involvement of family and friends. Although not specific for older people with mental health problems in general hospitals, it is likely that this group would be particularly prone to such loss of quality of care. Indeed, several of the stories used in the report to outline the problems (unreliable, depersonalized or leaderless care) were family members' experiences on behalf of confused, elderly relatives.

Bridges, Flatley and Meyer undertook a systematic review and synthesis of 42 qualitative studies and existing review of the experiences of older people and their families in acute hospitals[5]. They concluded that older people in hospital often do not feel in control of what happens, especially if they have impaired cognition. They identified three key features of care that consistently mediated these negative feelings and were linked to more positive experiences: "creating communities: connect with me", "maintaining identity: see who I am" and "sharing decision-making: include me".

In 2009, the Alzheimer's Society published "Counting the Cost"[6] a document highlighting the failings of the care of older people with dementia in hospital, derived from stories told to its research team. The following quotes illustrate its findings from the perspective of the patients and their carers:

'I can think of nothing positive from the moment my mother arrived. She was treated like a drunk on a Saturday night'.

'When we came to visit he had no bed and was lying on a mattress on the floor wearing nothing but an incontinence pad and a unbuttoned pajama top. The door to the room was wide open and he was in full view of other patients and their visitors. When we

enquired as to why this was, we were told that he had fallen out of bed the previous night and because of a shortage of special low beds he was on the floor for health and safety reasons. We found this very undignified and distressing'.

'Typical of the circumstances was illustrated when on three occasions when I visited my wife, she was sitting in the corridor, half dressed sometimes, and nobody seemed concerned or aware!'

'Completely disgusted. If animals were treated in the same way as Ida they would have been prosecuted'.

Stories such as these are not new or unknown to clinicians, and have been part of the motivation to create policies that can improve matters.

Policies

There are many general policy documents relating to the care of people in hospital, some of which specifically refer to those with mental health problems in general hospitals. The National Service Framework for Older People[7] represents the most important single policy document related to older people in the NHS in recent years. It comprised 8 "standards" or areas of activity including mental health (standard 7) and the care of people in hospital (standard 4). There are also several other reports and policy documents related more specifically to dementia and mental health:

- Who Cares Wins[1]
- Between Two Stools[8]
- Everybody's Business[9]
- Raising the Standard[10]
- New Ambition for Old Age[11]
- Dementia: Supporting people with dementia and their carers in health and social care. NICE Guideline[12]
- Academy of Medical Royal Colleges. Managing Urgent Mental Health Needs in the Acute Trust[13]

- Equality in Later Life. A national study of older people's mental health services. Healthcare Commission[14]
- No Health without Mental Health[15]
- Living well with dementia: a National Dementia Strategy[3]

The last of these, a National Dementia Strategy, reflects the need to tackle the health problems caused by dementia in a systematic way, especially with the increasing prevalence of the condition expected due to demographic change. This document focuses particularly upon improving awareness of the condition, partly in recognition of the role of stigma in preventing the condition being recognised or managed. It also promotes education and training. It has a specific section on the management of people with dementia in general hospitals which recommends that there should be clarity of responsibility for the management of dementia, including leadership and the development of clinical pathways, and that liaison old age psychiatry services should be commissioned to give access to specialist old age mental health teams. It is noteworthy that liaison old age psychiatry service should be proposed, and this is also the message in several of the documents cited above, including the NICE dementia guidance[12]. The functions of a liaison old age psychiatry service are described as:

- to make psychiatric diagnoses
- to identify people for transfer to hospital based or community based mental health teams
- to support existing general hospital staff in the management of individual cases
- to provide education and training for general hospital staff.

Several different models of services exist, including the use of single professionals or teams. Eight RCTs of variants of liaison old age psychiatry services were found by a recent systematic review[16]. The numbers in the studies were small, and the service models and outcome measures in the trials differed considerably. There was little evidence that mental health outcomes were improved using these services. Some services reduced hospital length of stay, and one study showed that the intervention was cost effective[17]. However, other studies showed increased lengths of stay and overall there was little evidence that outcomes were improved. Thus, there is little evidence that

liaison old age psychiatry services are cost effective. Without such evidence, there may be reluctance to develop liaison services, especially if to do so would be at the expense of existing community services.

Personhood, person centred care, relationship centred care and other psychiatric care models

Expert psychiatric care for people with dementia has been considered in the psychiatric and psychological literature, and developed in specialist psychiatric, care home and community settings. The concepts of person-centred care (and its variant synonyms such as patient-centred care) and the preservation of personhood in dementia are pervasive and dominant in the literature. The concept of personhood comes from the work of Tom Kitwood who is recognized as an intellect and pioneer in dementia care in the UK: "Personhood is a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being."[18]. It is argued that personhood is of central importance in the lives of people with dementia, and the loss of it represents the tragedy of the condition. It can be maintained in people with dementia by specific actions and approaches, but it can be diminished by society and individuals, including health and social services, particularly when value is attached to functions (such as cognitive capacity), or activities (such as those that maintain economic or physical independence) as opposed to valuing a person in a relationship and as a social being. The features of what he termed a "malignant social psychology" that does not respect personhood include:

- treachery or deceit
- disempowerment
- infantilization
- intimidation
- labelling
- stigmatization
- outpacing
- invalidation
- banishment

- and objectification

Central to avoiding these negative effects, and to the preservation and respect of personhood, he argued, is a person centred approach. The dementia literature contrasts with that of mental health conditions in younger ages (where conditions such as anxiety, depression and schizophrenia dominate) in which notions of recovery or living with the condition are prominent, and where physical and mental capacity are less of an issue. The malign features of services described by Kitwood can easily be imagined to be seen in people with mental health problems in general hospitals.

The concept of person centred care has been further refined by the development of the notions of "relationship centred care"[19]. Relationship focussed approaches emphasise the importance of relationships in maintaining or losing personhood – in particular the network of relationships between the person with dementia, their families, health and social care professionals.

There other model in the literature associated with psychiatric care. One is the "Tidal model"[20], designed for the care of people on psychiatric wards. This model of care is based on theories of relationships. It posits that the essence of psychiatric nursing care is in constructive and therapeutic relationships, but that practices in psychiatric services tend to weaken the amount of time patients and staff spend forming and using these relationships. The tidal model describes a transformational process, strongly dependent upon good and empowered leadership using observations of practice to provide the information to facilitate change. A key focus is on the amount of nurse-patient contact, and the quality of that contact.

A more recent and specific attempt to improve the nursing care of people with mental health is described by Norman, who developed practice guidelines based upon her PhD work on the care of people with dementia when admitted to a general hospital[21]. Her model indicates how the relationship between the nurse and the person with dementia, can work positively or negatively. She came up with three themes to guide nursing practice: defining "memory problems" differently (this involves understanding what patients and their families mean by memory problems); understanding action (this

involves understanding why patients act as they do and how nurses' actions are interpreted and affect the patient's behaviour); and putting the person first (a variant of person-centred thinking). This model of care is grounded on the recognition that memory problems often explains abnormal behaviour and that they typify the problems experienced in caring for these patients. It is consistent with thinking that concentrates on the needs of the patient.

Care models in general hospitals

The most common generic nursing model of care in the UK since the 1980's is probably that of Roper Logan and Tierney[22]. This model is based around the assessment and management of twelve activities of daily living:

- Maintaining a safe environment
- Communication
- Breathing
- Eating and drinking
- Elimination
- Washing and dressing
- Controlling temperature
- Mobilisation
- Working and playing
- Expressing sexuality
- Sleeping
- Death and dying

These twelve factors are understood to be influenced by biological, psychological, socio-cultural, environmental and politico-economic factors, and this is to be taken into account during clinical assessment.

The emphasis of this model of care contrasts with the psychiatric models described earlier. This model is centred upon activity: cognition is not one of the 12 core areas of interests. In contrast, the psychiatric models focus on relationships, and understanding

behaviour from the patient's perspective and recognizing the importance of their cognitive deficits. The model of Roper, Logan and Tierney might be better suited to a younger patient with a traumatic injury and than an elderly one with memory loss, depression and agitation alongside multiple functional problems.

Although the initial notions of person centred care began in dementia care, it has been adopted for general use where it is understood partly by what it is not - doctor centred, disease centred, or hospital centred. It can be seen as a reaction to medical paternalism's disregard for personal, social and cultural variation in views, goals and preferences. Person centred care in its general sense is characterised by being user focused, with an emphasis on respecting autonomy, offering choice, and flexibility so that services can be individualised. User focussed services are likely to consult users, or involve them in the design or delivery of the service. User focussed services are likely to concentrate upon qualities such as patience, compassion, sensitivity and empathy rather than solely on their technical effectiveness or efficiency. In this general sense, person centred care is explicitly important to the NHS: it is the second of the eight standards laid down in the National Service Framework of Older People[7], and features heavily throughout the National Dementia Strategy[3].

The environment

Just as the care models for people in general hospitals may not be suitable for many of those with dementia who use them, so too might the environment of hospitals be unsuitable. The literature in this area is particularly influenced by notions of person centred care and the need to design environments around the needs of the people they are housing. Although this might seem obvious, this approach contrasts with arrangements where patients are managed in settings that were not designed for the purpose for which they are now used, such as hospital wards housing elderly patients designed for the isolation of people with infectious diseases.

A review by Day et al[23] (citing 107 references) considered the design of environments for people with dementia, and hence focussed upon research in settings providing long term respite or day care, rather than the general hospital. The review highlighted the

methodological difficulties in attempting to distinguish the effect of an environment upon outcome, and much research in this field is observational rather than experimental. A second review by Daykin et al[24] (citing 51 references) considered the impact and perceptions of art and design on mental health care. Again, methodological difficulties were noted. Day argued that many aspects of ward and hospital design, such as those that maintain privacy and hence dignity, are so obvious so as not to be subject to evaluative research. This may not be so: in a hospital single rooms would clearly be better for privacy than open bays, but there may be drawbacks such as reduced ability to be monitored, or a lack of social stimulation: personalising the space around a patient may improve their satisfaction with their environment, but there could be risks in terms of harbouring nosocomial infection. Both reviews however illustrate the range of more specific topics considered in the literature. Of potential relevance to this review:

- Several papers reported that people with dementia relocated to a new setting suffer higher rates of depression and higher mortality than those not relocated. This could, potentially, apply to those entering hospital
- Studies reviewed on respite care settings comment that those at low levels of functioning can improve in such settings but those with higher levels of function can decline (perhaps due to restrictions imposed by the setting that do not apply at home). Again, these tendencies could apply in hospital. A HTA monograph has reviewed this topic[25].
- Studies have compared special care (residential) units for people with dementia with non-specialist units. The former tend to be smaller, have private rooms and spaces, opportunities for leisure. A range of studies with positive benefits to the people with dementia are reported (reduction in the behavioural and psychological symptoms of dementia) and also a reduction in stress in their relatives who visit them. However a range of neutral studies are also reported and one showing no benefit in terms of staff job satisfaction. By creating special units for dementia this can reduce the proportion of such people in non-specialist units, and there have been benefits reported in the non-cognitively impaired residents of such units. An analogous concern with older people with mental health problems in general hospitals is the effect they may have on nearby younger patients or those without mental health problems.

The general aspects of the environment in special units to which benefits have been attributed include those that:

- Give rise to a non-institutional character (such as home-like furnishings)
- Prevent inappropriate sensory over-stimulation (such as having the space to screen residents from distracting activities elsewhere in the unit, and avoiding overcrowding), and those that encourage positive sensory stimulation (such as recreational materials or nature sounds such as running water or birdsong)
- Provide adequate lighting and visual contrast, particularly for those with co-existing visual deficits. There is also a literature on the value of bright light and its effect upon circadian rhythms and hence disruptions to mood and daily activity patterns.
- Improve safety. These include examples such as a full length mirror on a door to prevent residents from attempting to exit the unit inappropriately, signage to direct residents towards suitable areas such as a toilet or garden, or design features that enable better surveillance
- Promote orientation. Personally significant memorabilia can be used to help residents distinguish their own rooms from those of others. Short corridors and simple decision points are helpful: long, distracting corridors with many different doors leading to many different other rooms are unhelpful for a person who wishes to go swiftly to the toilet
- Provide outdoor areas. Aggressive behaviour and sleep disturbance are reported to be reduced where there is access to the outdoors.

Evidence was also reviewed for specific rooms:

- Bathrooms and bathing, especially given the frequent need for specialist equipment and assistance from care givers, can be frightening and compromise dignity. An experiment was cited in which nature sounds (water and bird song) reduced agitation during bathing.
- Toilets benefit from clear signage (which may need to be floor mounted for those with stooped posture) and being large enough to accommodate wheelchairs.
- Dining rooms with a non–institutional character tend to improve eating behaviour

The review by Daykin et al considered the role of art in hospitals. Five studies evaluating the role of art were reviewed. Reported benefits included reductions in patient anxiety and stress, reduced vandalism, and better staff morale – one large UK study reported that its funders considered the range of perceived benefits of installing artworks compared to other infrastructural or staffing funding, represented extremely good value for money.

Planetree[26] (a non-profit organization to facilitate patient centered care health care organizations) provides, amongst its many outputs, a description of an environment from this perspective. Planetree's description of a patient-centered environment begins by stating that the first impressions are welcoming, with artwork and comfortable seating suitable for those seeking privacy or social interaction. It goes on to state that parking is easy, and signage to the ward is clear. Staff are on hand to greet and direct patients and their families, and routes are well waymarked. Ward clutter is removed and medical equipment is disguised. Families are accommodated including areas for them to read or chat, including overnight accommodation. Views of nature, such as gardens or a fish tank, are present. Unpleasant or loud sounds (such as equipment alarms) are reduced and soothing music is used in certain areas. The importance of smell is considered such as to avoid the unpleasant ones and replacing them with more pleasant ones such as with aromatherapy. Planetree's recommendations represent an idealistic view of a healthcare organization, but they argue that facilities of this nature are not impossible and indeed they accredit certain facilities that meet its standards. Although it is not conventionally research evidence based and there are no details about how such elements of an environment could be introduced into a typical UK NHS general hospital, the contrast between the Planetree vision and a typical NHS hospital in the start of the 21st century helps to illustrate aspects of typical hospital wards that are not patient centered.

Management of specific problems

A less holistic approach to dementia care than the person centred approach, or environmental change, is to use specific interventions for specific problems. A particular example is the management of difficult or inappropriate behaviours. Cohen-Mansfield[27]

reviewed 83 articles evaluating non-pharmacological interventions for inappropriate behaviours in dementia including physically aggressive behaviours, physical nonaggressive behaviours such as pacing or interfering, verbal non-aggressive such as constant repetition, and verbal aggression such as swearing or screaming.

She described the behaviours using three underlying theoretical models:

- the behaviours are a manifestation of unmet needs
- they are the consequence of conditioning or
- they are a consequence of a reduced stress threshold.

She classified the interventions into those that were:

- sensory
- social and interactive (including pets)
- behavioural therapies
- staff training; physical activities
- environmental changes
- medical and nursing
- a combination interventions.

Three quarters of the studies were in care homes, the remainder in hospitals. As summarized in the table below, the majority of these interventions were reported as having positive effects. She concluded that there is a range of promising interventions which provide a range of possible options for the general hospital to explore when dealing with people with co-morbid mental health problems. The review did not critically examine the methodology of these studies, and it seems highly likely that there are other reasons to explain this overall positive picture such as the Hawthorne effect and the differential publication of small positive trials over similarly small negative ones.

Intervention	Summary of benefit to behaviours
Massage	6 studies mainly positive

Music	7 studies, mainly positive
White noise at night	2 reports: no clear picture on sleep
Sensory stimulation	1 report: positive
Pet therapy	3 studies: positive
One to one	2 studies: positive
Family videos	3 of 4 studies positive
Behaviour therapy: differential reinforcement	7 studies positive
Behaviour therapy: stimulus control	5 of 6 studies positive
Behaviour therapy: reality orientation	1 study: neutral
Staff training	5 of 6 positive
Structured activities	4 of 5 positive
Environmental	6 studies: positive
Medical / nursing: light therapy	8 studies, 6 of which positive
Medical nursing: pain	1 study: positive
Medical / nursing: hearing aids	1 study: positive
Medical / nursing: removal of restraints	2 studies: positive
Combinations	5 studies: 4 positive, 1 negative

Robinson and colleagues[28] conducted a more focused review on interventions to reduce wandering in dementia. This review included 11 studies, 8 of which were RCTs and undertook an assessment of the methodological rigour of each study. Most studies were in long term care settings. This review included sensory interventions, music, exercise, and behavioural therapy. In a different tone from Cohen–Mansfield's review (although she was acknowledged as one of the reviewers in this in this paper) it was concluded that there was no robust evidence of effectiveness of these interventions, although weak evidence in favour of the use of exercise was noted. This review also considered reported evidence on the acceptability and ethical issues: physical restraints were considered unacceptable.

In summary, research studies in patients with problems such as wandering or shouting are difficult to conduct, and have largely been conducted in long term care settings.

There is no proven single intervention for any or all of the behavioral and psychological problems of dementia, but there is a range of potential interventions staff in general hospitals could take when faced with patients with these problems.

Securing better mental health for older people in general hospitals

It is not clear how or whether psychiatric liaison services, the model proposed in the National Dementia Strategy, would affect the quality of care in general hospitals if the prevailing models of care are not person-centred. Presumably this would be through education and training of ward staff rather than the psychiatric staff taking over the care of individuals. Kitwood and others have attempt to operationalize a form of management that is person centred, that respects personhood, and that delivers a better quality of care than alternatives. One response to this challenge has been the development of Dementia Care Mapping[29] which is promoted by the Bradford Dementia Group[30], UK (founded by Kitwood). At a simple level, it is a tool to assess the quality of care. However, it is clear that the intention is that it not only a measurement tool but a means to encourage education and transformation. In essence, in Dementia Care Mapping, the care of a person with dementia is observed, typically by a caregiver or professional, and the observations are recorded using a structured tool that requires the observer to consider the person's mood and type of activity they are engaged in and the quality of staff interactions with the person being observed. Results of the observations are discussed with staff members. The Dementia Care mapper acts as a facilitator to enable the staff of the ward or care home to identify ways of improving the care of the residents. In this way Dementia Care Mapping can facilitate a process of continual quality improvement. Brooker's review[29] considered 34 research papers on Dementia Care Mapping: 11 studies used it to perform cross sectional studies, 10 studies used it to evaluate interventions (i.e. as an outcome measure); six studies used it in continuous quality improvement (i.e. as an intervention as well as an outcome measure); in 3 studies it was used as part of a multimethod evaluation; and in 4 articles its psychometric properties were examined. She reported that as a measurement tool it is time consuming (reliable measures require at least 4 hours of observation) and hence resource intensive. She also pointed out that it is difficult to assess the value of

Dementia Care Mapping as an agent of change in studies when it is also the measure of outcome.

The NHS has generic quality enhancement processes that might be harnessed, but to date these have not explicitly aimed at improving the quality of care of people with dementia by attempting to deliver care along the lines of specialist dementia services. An example of a generic process in NHS hospitals is a benchmarking process known as the Essence of Care, promulgated by the NHS Modernization Agency[31]. This comprises eight inter-related "client focussed" benchmarks, one of which is "Benchmarks for safety of clients with mental health needs in acute mental health and general hospital settings". Six domains form part of this benchmark, and they concern: orientating the "client"; assessing the risk of them harming themselves or others (two domains); balancing observation and privacy; meeting safety needs; and a positive no-blame culture. This benchmark is clearly focussed on risk management and appears to be designed mainly for acute mental health units and younger patients with mental health problems. It does not seem to address explicitly the special problems of older people with disability, sensory loss or cognitive impairment. Being a governance tool, it is heavily focussed on assessment of risk (perhaps with suicide or violence in mind) rather than, for example, the risk to health or more subtle concepts such as personhood. Another example is the "Productive Ward", which is a self directed learning programme from the NHS Institute for Innovation and Improvemen[32], designed for hospital wards. This has had wide uptake throughout the NHS. The version for general wards focuses mainly upon promoting efficiencies to free up "time to care". This could be helpful if inadequate time, rather than inadequate training or processes, is a barrier to the delivery of person centred care.

Rather than educational processes, it might be that legal or regulatory approaches might be used. For example, the Mental Capacity Act[33] 2005 of England and Wales now specifies how capacity should be assessed, and how decisions should be made when capacity is lacking. One could argue that this provides a legal basis for the rigorous application of these principles to the management of people with dementia (who by and large do not have the capacity to complain or insist upon the right care). However, the UK's health system has generally tended not to invoke the rule of law and there seems no appetite or arrangements made to ensure that this piece of legislation is policed. The

role of the Independent Mental Health Care Advocate (IMCA) scheme, which is part of the Mental Capacity Act, is to give advice in difficult cases, rather than to police the health care system's adherence to the Mental Capacity Act. The Care Quality Commission[34] is the independent regulator if health and social care in England. In recent times it has shown interest in dementia care in care homes, the mental health care of people with intellectual disabilities, acute mental health care and (in its previous guise as the Healthcare Commission) it has also made a high profile public criticism of a NHS hospital (the Mid-Staffordshire NHS Foundation Trust)[35], showing that the CQC has "teeth". Lessons learned from the public exposure of that hospital have been noted throughout the country. Presumably the CQC could make an example of any general hospital regarding the care of patients with mental health problems.

One legal means through which hospitals in England could be subject to legal sanctions is from local authority health overview and scrutiny committees[36]. These have powers to demand changes in hospitals if they are believed to be unsatisfactory.

In the absence of legal or regulatory pressures, NHS hospitals are likely to continue employing measures similar to the Essence of Care and the Productive Ward to effect change. As the Point of Care review pointed out, change could be effected at the level of the interaction of the patient and family, at the level of individual staff members, but also at progressively higher levels – the team, the hospital, and the wider health care system. A general model illustrating the relationship of organisational factors to patient safety, care and experience, taken from the Healthcare Commissions NHS Staff survey 2003[37] is shown below.

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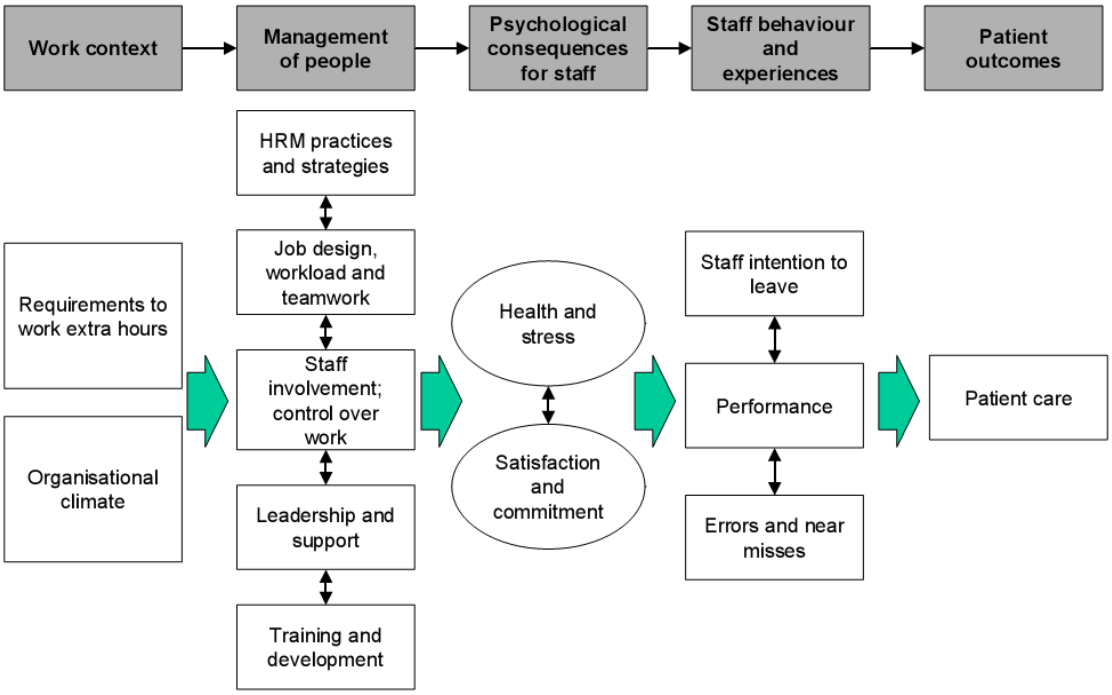

The Better Mental Health research study aims to examine in some detail how and what level better care can be delivered, building upon notions of person centred care, the evidence of benefit of environmental change and of specific therapies, and also building upon change management processes already within the NHS.

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