

# Quality improvement project to improve the standardisation and efficiency of occupational therapy initial contact and assessment within a mental health inpatient service

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## ABSTRACT

Timely contact and assessment between occupational therapists (OTs) and patients are vital to understanding their needs and creating person-centred interventions. Any delays in completing contact and assessment will likely impact patients' experience and outcomes. The aim of this study was to ensure that 90% of all patients in a male and female ward received OT initial contact within two working days of admission by the end of June 2020.

With the teams working in collaboration, the first change idea of increasing the initial contact in two working days was introduced and the impact assessed on two of the five wards. The Plan–Do–Study–Act cycles used for this test of change included: Standardising the initial contact, informal training for the audit tool created to measure the admission process, increasing efficiency for documenting OT contact, updated exclusion/inclusion criteria for OT initial contact, refining documentation for contact and assessment, and the impact of COVID-19 on initial contact and admission processes.

Our test of change resulted in an increase in the average initial contact from 12.5% to 71.24%. Following this success, we spread the project to the three remaining wards. Feedback from OTs using the tools we introduced ensured that we made tools as user-friendly as possible. Likewise, teams who achieved particularly high compliance noted the importance of dedicating time to conduct initial contact.

Our team embarked on a quality improvement project that aimed to set a standard and increase compliance for achieving this standard. Alongside this, we developed an appropriate and pragmatic measure to track our progress. While we did not achieve 90%, we observed substantial improvements made across the participating service. Using the findings from the project, we have spread this approach to other wards and believe that it could easily be transferrable as a discreet package to other mental health settings.

## PROBLEM

Mental health trusts are responsible for seeking ways to improve recovery and ultimately reduce lengths of stay, where appropriate, for the inpatient services users they support. Occupational therapy (OT) was

## WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ A previous paper introduced prioritisation protocols to promote efficient and effective allocation of mental health Occupational therapy resources. This included proposals for timely initial contact and assessment. This study recognised the lack of practice-focused evidence for implementing a standardised approach to initial contact and assessment from that paper.

## WHAT THIS STUDY ADDS

⇒ Our paper provides a clear and replicable account of how standardised initial contact and assessment was achieved using quality improvement approaches.

## HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ It adds to the improvement science literature by providing a reflective account of our quality improvement project, drawing on systems thinking, iterative learning through continuous improvement and meaningful engagement.

founded based on the principle that occupational performance is vital to health and well-being.<sup>1 2</sup> This gives OTs the unique perspective towards health promotion, especially with regard to how occupational factors impact health and well-being.<sup>3</sup> OTs recognise that timely interventions can: prevent unnecessary hospital admissions; advance well-being and patient experience; enable early discharge; facilitate recovery and social inclusion; support the achievement personalised outcomes; and help adults of working age to retain their jobs or obtain employment.<sup>4</sup> As such, timely contact and assessment between OTs and patients are vital to understanding their needs, creating person-centred interventions, and starting an individualised plan supporting their recovery journey. For example, within the Oxfordshire adult acute



mental health wards, timely contact, and assessment enables care-package assessments from social workers, self-care and sensory plans for nurses and healthcare assistants to support patients and ascertain the safety of the discharge destination. Consequently, any delays in completing contact and assessment will likely impact a patient experience and outcomes.

Despite the apparent benefits of timely contact and assessment, many adult acute inpatient OT services across the Oxford Health NHS Foundation Trust (OHFT) had difficulties maintaining a consistent and prompt approach. This was further compounded by no accurate measure to audit when staff carried out contact and assessment tasks, making it very difficult to understand our current performance objectively and would impact on understanding whether our proposed changes would lead to an improvement.

To aid a timely approach to understand our patient's needs, we wanted to improve our initial contact to be within two working days of admission and assessment within five working days of admission. We aimed to improve the timeliness of our initial contact (within two working days of admission) and assessment (within five working days of admission) against an established standard set by previous research.<sup>5</sup>

Across several meetings, the project team agreed an aim to ensure that 90% of all patients in a male and female ward received OT initial contact within two working days of admission by the end of June 2020. The team agreed to focus on initial contact, which would spur the team to engage in further contact in a timelier manner.

## BACKGROUND

The NHS long-term plan consists of a vital goal to reduce the length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings.<sup>6,7</sup> This plan proposed an improvement in the therapeutic offer from inpatient mental health services by increased investment in interventions and activities, resulting in better patient outcomes and experience in the hospital, thus reducing the length of stay.

OT constitutes an integral part of the interventions and activities that reduce lengths of stay in acute mental health hospitals.<sup>5</sup> Contact from OT services provides patients with the opportunity for patient involvement in what interventions matter to them and promotes the principles of person-centred care and recovery-oriented practice.<sup>8,9</sup> Initiating these processes empower patients to share decision-making and self-directed care, both essential components in mental health services and patient well-being.<sup>10</sup>

One significant challenge in mental health is simultaneously improving the productivity of staff and enhancing healthcare quality.<sup>11</sup> In particular, for OT, the challenge is to produce clinically focusing on reducing lengths of stay in acute mental health settings.<sup>12</sup>

Our project took the first step to ensuring timely initial contact and assessment to ensure that patients had maximal opportunity to receive individualised care. As such, this project served as a bedrock for possible future quality improvement (QI) projects.

## MEASUREMENT

### Baseline measurement

During successive OT business meetings, we discovered that team members carried out admission processes differently. In our OT networking meeting in August 2019, the network of adult inpatient OTs throughout OHFT—consisting of adult inpatient OTs from Oxfordshire and Buckinghamshire—conducted a process mapping exercise to review to see how the teams compared with the proposed timescales and whether there would be any barriers to achieving our aim.

Using process mapping, we compared teams in the Oxfordshire and Buckinghamshire services. We discovered that the two teams varied in the extent to which they took a standardised approach to admission. Further downstream, we observed no significant inconsistencies in intervention and discharge process in Oxfordshire and Buckinghamshire.

With the teams working in collaboration, the OT team in Oxfordshire decided to develop a QI project to improve the admission process because of the inconsistencies observed during the process mapping. The admission process in the five wards that made up the Oxfordshire inpatient services was further analysed. We observed that some of the wards were not meeting the Standards for Accreditation of Inpatient Mental Health Services (AIMS). In particular, the initial contact within two working days (AIMS 2.11 & 2.12) and initial assessment within five working days (AIMS 2.26).<sup>13</sup> Furthermore, only one ward was meeting the two- and five working days OT admission process. The reason was due to a lack of awareness about the OT process and vacant OT positions.

This information led the team to conduct a baseline diagnostic assessment in the form of an audit of the OT admission process on this ward.

### How the information was acquired

Three patients were randomly selected for each month from April to December 2019 (see table 1) except in August (only one patient's data was available) and September (no patient data available). We checked correspondence files on Care Notes (electronic patient record) for initial contact and assessment documentation. We also checked the OT's initial contact and assessment records in the first five days and noted any patient refusal to engage. The team agreed on several points concerning the measurement strategy. These were:

- ▶ The documented refusal of a patient to engage in an initial contact is scored as a completed contact.
- ▶ The completion of an initial assessment within two working days is evidence that the initial contact had

**Table 1** Baseline audit indicating initial contact and initial assessment

Year 2019	% Score for initial contact (two working days)	% Score for initial assessment (five working days)	Total percentage admission process
April	0	66.7	33.35
May	0	100	50
June	0	33.3	16.65
July	66.7	33.3	50
August	0	0	0
October	33.3	66.7	50
November	0	33.3	16.65
December	0	0	0
% total from April to December 2019	12.5	41.67	27.10

taken place because there was no standardised definition of an OT initial contact within the admission process at the time of the baseline assessment.

- ▶ A score of 1 each for initial contact in two working days and initial assessment in five working days. The percentage compliance for initial contact and assessment can be viewed in [table 1](#).

The baseline audit indicated that 12.5% completed the initial contact and 41.67% completed an initial assessment from April to December 2019.

## DESIGN

The baseline audit informed the OT team decision to implement changes that would improve the admission process. We held monthly team business meetings to discuss possible tests of change that would improve the admission process. They also served as supportive sessions to discuss concerns, ask questions and analyse the monthly audits. At the time of the first meeting, the team consisted of a clinical lead OT (lead researcher) and two band 5 OTs from the Male and female wards. The team received support from the Trust's QI team throughout the project. The band 6 OTs for the remaining two wards joined the OT business meeting after recruiting them in April 2020 and August 2020 respectively. We regularly updated progress at the ward manager's meeting to ensure full integration into practice.

We created a driver diagram (see online supplemental appendix C) and used it in business meetings to identify and agree on the most achievable test of change. The team proposed that improving the initial contact of patients was the most feasible change that could improve the admission process. This test of change involved standardising the initial contact and increasing competence with the audit tool created to measure engagement in the admission process.

## STRATEGY

### Test of change: increasing initial contact

We started our test of change on two wards (one male and one female) from January to the end of June 2020. The choice of both wards was because the OTs on both wards were enthusiastic to implement the changes suggested in their practice and their ward managers were keen to support this change. We conducted a monthly audit to measure engagement in initial contacts and monitored progress in monthly OT team meetings.

The OT team met monthly to monitor the test of change on the two wards. These meetings provided an opportunity to iteratively develop the test of change based on feedback from the team. This was especially important during COVID-19 as the team needed to align practice changes to the continual changes in guidelines. The awareness about this test of change and the corresponding Plan–Do–Study–Act (PDSA) cycles was raised through presentations in the weekly ward managers business meeting of the five wards in the acute adult inpatient service. It was particularly important for each ward to understand the project and the changes being made to aid implementation into current practice. Especially as the information collected feeds into care planning across different disciplines in the service. These meetings consisted of the social workers, nurse clinical leads, clinical lead OT (research lead), ward managers, matrons and a senior matron.

### PDSA 1 and 2 (January 2020)

#### PDSA 1: standardise the initial contact

##### Plan

We standardised the OT initial contact process to be able to measure it. The team made this decision based on the findings of the baseline audit, which indicated a lack of standardisation for initial contact of OTs.

The team proposed four criteria required when conducting an initial contact with new patients on acute

wards. The criteria included meeting the patient within two working days of admission as specified in the admission process, introducing the OT role on the ward, signposting the patient to available activities on the ward, and scheduling a date and time within five working days of admission for the initial assessment. The team agreed for the clinical lead OT to audit the number of standardised initial contacts completed monthly on both wards. The team agreed for a score of one each for initial contact in two working days and initial assessment in five working days.

#### Do

The team carried out the agreed standardised process and agreed timeframes with the view of reviewing the data and feedback.

#### Study

The OT team met and agreed that the data of 45.58%, for OT initial contact and 45.65%. was an improvement on the previous month (December 2019) but we needed a higher percentage to meet the 90% initial contact score as identified in the aim. The OT team discussed the reason why the percentage initial contact was lower than the aim. We agreed that the ward was extremely busy, and the OTs struggled to document their initial contact despite completing this. The team also established that they struggled with the inclusion and exclusion criteria for the initial contact. This included patients in 136 suites.

#### Act

The OT team agreed to engage in two PDSAs simultaneously in February (2020). For the first PDSA, increase the efficiency of OT initial contact documentation. The second PDSA was to clarify the inclusion and exclusion criteria for initial contacts of patients. We set a target of 60% for the initial contact for February 2020.

### PDSA 2: informal training for the audit tool created to measure the admission process

#### Plan

The lead OT presented the audit tool to the team using Microsoft PowerPoint and used a patient case file to demonstrate documenting initial contact and assessment. A score of 1 each was given for documented initial contact within two working days and initial assessment in five working days, and a score of 0 if either were missed. We supported team members to practice the audit on the different casefiles and increase their confidence in the new procedure.

#### Do

We carried out the plan and collected the data from the monthly audits at the end of January 2020.

#### Study

The data collected showed that initial contact was at 45.58%, and initial assessment at 45.65%. Subsequently, the OTs felt empowered to be able to use their audit to

serve as a reminder and monitor the timeliness of initial contact. Please see other details provided in PDSA 1, as both PDSA 1 and 2 were carried out simultaneously.

#### Act

Please see the details provided in PDSA 1, as both PDSA 1 and 2 were carried out simultaneously.

### PDSA 3 AND 4 (FEBRUARY 2020)

#### PDSA 3: increasing efficiency for documenting OT contact Plan

During this business meeting, the audit data indicated a team member was struggling to complete the initial contact. The OT team agreed that it would be beneficial to construct a generic template for initial contact consisting of the name of the OT, role and responsibilities. The participating OTs would then add the content of their discussions with patients during the initial contact to the template and document it on their electronic notes to reduce time spent on documentation.

Another team member identified that there was a difficulty to write up comprehensive notes after conducting the initial contact and assessment. The team agreed on an admin half day in the library every Thursday and using the last hour of the day to document summaries of the initial contact. Other OTs in the business discussed the use of novel spaces such as the OT kitchen, booking meeting rooms and using ground walks where section 17 leave was available.

#### Do

The team introduced the generic template for initial contact and to use this during the initial meeting with patients. The team agreed to provide feedback on the form during monthly meetings and via email on an ad hoc basis.

#### Study

At 69.50%, the data for initial contact exceeded the target of 60% for February 2020. Initial assessments also increased to 50%. The OT team agreed that having a template for initial contact and during the monthly business meeting, the OTs discussed other ways of increasing the efficiency of the initial contact. The OT on the female ward asked if OTs could document the contact and assessment on the same clinical note when carried out in the same session.

#### Act

The team agreed to carry out this suggestion as a PDSA in March 2020. We set a target of 70% for initial contact.

### PDSA 4: updated exclusion/inclusion criteria for OT initial contact

#### Plan

The team discussed documenting the criteria as part of the OT initial contact. We also discussed the requirements concerning the initial contact of patients admitted



into the 136 suites and patients in seclusion. The team clarified that people were not technically admitted into the 136 suites on the main wards. As a result, they did not require OT contact. In terms of seclusion, the team agreed that OTs should document their inability to establish contact with patients in seclusion after two working days of admission. We agreed to record this as an attempted contact and note to re-establish contact when the patient exited seclusion.

#### Do

OTs on both wards carried out the plan and collected the data from the monthly audits at the end of February 2020 because they had been trained previously on how to use it. The lead therapist checked the audit to ensure its accuracy. The data collected showed that initial contact increased to 69.50% and initial assessment increased to 50%.

#### Study

The OTs commented that increase their efficiency by focusing on patients within the inclusion criteria Please, see other comments in PDSA 3, as both PDSA 3 and 4 were carried out simultaneously.

#### Act

Please see comments in PDSA 3, as both PDSA 3 and 4 were carried out simultaneously.

### PDSA 5 (March 2020) refining documenting contact and assessment

#### Plan

The team agreed to document the contact and assessment on the same clinical note when carried out in the same session.

#### Do

OTs on the two wards carried out the plan and collected the data independently from the monthly audits at the end of March 2020. The data collected showed that initial contact decreased to 51.67% but initial assessment increased to 68.30%.

#### Study

The initial contact for March 2020 did not meet the target of 70%. The Team discussed the reason behind the drop in the percentage of initial contacts. This was attributed to the holiday rush in March, where the OTs involved in the project had to use up their holidays before the next financial year. The OTs said that the time duration of two working days for initial contact elapsed faster in comparison to the initial assessment of five working days.

#### Act

The OT team agreed to observe the initial contact data over the months of April and May 2020. In April, the initial contact scores increased to 90% and initial assessment increased to 70%. In June 2020, the initial contact was 81.60% and the initial assessment was 90.85%. The

initial contact data for both months exceeded the 70% set in the previous PDSA.

### PDSA 6 (June 2020) impact of COVID-19 on initial contact and admission processes

#### Plan

The team analysed the Impact of COVID-19 on this project. We agreed that as part of our compliance with the COVID-19 guidelines, we would start counting the working days for initial contact after patients were out of isolation and confirmed to be COVID-19 negative. This protected OTs from an increase COVID-19 infection risk. The monthly audit reflected this from July 2020 as part of the spread described in the results section. A target initial contact of 80% was set for the Month of June. Ward managers for both wards were informed in the weekly ward manager's business meeting. They agreed with this plan and asked for updates on the progress of this PDSA.

#### Do

OTs on the male and female wards carried out the plan and collected the data independently at the end of June 2020. The initial contact was 85.85% and initial assessment was 85.83%.

#### Study

The initial contact exceeded the target of 80%. The OTs attributed this to following the guidelines of the five previous PDSAs.

#### Act

The team agreed that they were comfortable to continue following the guidelines of the PDSAs. They also agreed that it was time to spread the learning from the PDSAs to the other wards.

## RESULTS

This test of change indicated that the Initial contact increased from an average of 12.5% (April to December 2019) to an average of 71.24% (January 2020 to June 2020) on the male and female wards (table 2, online supplemental appendix A). Initial assessments also increased from an average of 41.67% (April to December 2019) to 69.27% (January 2020 to June 2020). We observed a shift

**Table 2** Monthly audit and the impact of the test of change

Month	% initial contact	% initial assessment	% admission process
January (2020)	45.85	45.65	45.75
February (2020)	69.50	50	59.75
March (2020)	51.67	68.30	60
April (2020)	90	75	82.5
May (2020)	81.6	90.85	86.2
June (2020)	85.85	85.83	78.75
% average	71.24	69.27	70.26



in the data during the 6-month period for the project and before the spread to other wards (see online supplementary appendix A, B in supplementary file for the run charts). Following this success, we spread the project to three further wards. Between July 2020 and July 2021, an average of 78.38% of patients were contacted within two working days and 72.13% of patients were assessed within five working days across the five adult wards within the Oxfordshire Adult Inpatient service.

## LESSONS AND LIMITATIONS

Inevitably, the pandemic impacted this project, and we subsequently made pragmatic adaptations to enhance the project sustainability. First, all newly admitted patients had to undergo an isolation period and test negative for COVID-19 before coming into the ward. Therefore, we revised the two-day window for initial contact after a patient came out of isolation. We also experienced difficulties due to social distance restrictions when completing initial contact on the male ward. As a solution, OTs used spaces such as the kitchen, meeting rooms and library spaces to complete initial contact and the associated documentation. This novel way of working was shared with other OTs in monthly business meetings and adopted by other wards. This demonstrated the importance of utilising novel spaces that may sometimes be outside of your immediate environment.

We have focused our reflections on sustainability in a more practice-focused manner and considered these against the five sustainability principles developed by the Royal College of Psychiatrists.<sup>14</sup> We ensured that there were no extra financial, social or environment costs incurred during this project by discussing and running PDSA cycles within pre-established business meetings and spreading the multidisciplinary team awareness of this project through pre-established manager's meetings. To aid sustainability for the proposed changes, we created an induction pack to ensure that all new OTs understood our processes for initial contact and assessment. This approach further promoted continuity within this project. Another area explored in this project was the impact on staff sustainability. During the spread of the project to other wards, the audit data was key to assessing the well-being of OTs during the project. We noted that a drastic reduction in initial contact or assessment in a ward at times indicated that an OT was struggling with their health and well-being. In such situations, support systems were put in place such as increase in the frequency of supervision and referral to occupational health. Nonetheless, due to a change in employment of the author, the long-term sustainability of this project could not be ascertained.

Another limitation was that balancing measures such as admission rates were not considered during the project. Nonetheless, there is a limit to the number of admissions because of a set number of bedspaces on the wards. Since admission rates could not exceed available hospital beds,

the variation in results would likely not be significant. Any future work on this project should also consider the possible impact on staff working conditions (e.g., patients in COVID isolation) and staff retention.

We realised the importance of an iterative and systems-led approach to projects, such as ours, that require introducing new ways of working and increasing compliance. First, we ensured that we listened to the feedback of OTs using the tools we introduced and incorporated these changes to make these tools as user-friendly as possible. Second, those teams who achieved particularly high compliance mentioned the importance of dedicating time to conduct initial contact. This shows that projects do rely on systems providing the right time and resource, and the importance utilising the feedback from team members to continuously optimise tests of change.

Finally, while timely assessment is important to set patients on the path of individualised care, OTs should consider whether the patient is able to discuss and contribute to their recovery. The quality of their interaction is as important as when it happens.

## CONCLUSION

OT services play a vital role in aiding service users in inpatient mental health services to aid their recovery, help them seek meaningful participation in day-to-day life and prepare them to return to the community. To ensure a person-centred approach to healthcare, OTs must promptly conduct initial contact and assessment to establish patient needs and create an individualised plan shortly after admission.

Recognising the importance of timeliness, our team embarked on a QI project that aimed to set a standard and increase compliance for achieving this standard. Alongside this, we developed an appropriate and pragmatic measure to track our progress. While we did not achieve 90%, we observed substantial improvements made across the participating service.

Our project demonstrates the importance of a systematic and engaging approach to QI. Through all stages, project staff contributed meaningfully to what matters and what we should test. Our approach focused on a small but practical test of change with rapid iterative cycles through multiple PDSAs. Furthermore, we recognised the importance of having a reliable measure and created one that become a core part of the project. Utilising the findings from the project, we have spread this approach to other wards and believe that it could easily be transferrable as a discreet package to other mental health settings.

While we achieved the aim of increasing the timeliness of initial contact, our ultimate goal is to determine whether this impacts patient outcomes (level of recovery & duration of stay) and patient experience. Using a continuous improvement lens, the next stage of this work is to see whether timely assessment leads to improvements in aspects such as increased participation in engaging

interventions, how this influences their recovery, and ultimately whether it impacts the duration of stay.

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## REFERENCES

- 1 Parkinson S, Forsyth K, Kielhofner G. *A user's manual for Model of Human Occupation Screening Tool (MOHOST). The Model of Human Occupation Clearinghouse*. Department of Occupational Therapy, University of Illinois at Chicago, 2004.
- 2 Patterson C. A short history of occupational therapy in psychiatry. In: Creek J, Lougher L, eds. *Occupational therapy and mental health*. Edinburgh: Churchill Livingstone, Elsevier, 2008: 2008. 3–16.
- 3 Royal College of Occupational Therapists. *Occupational therapy evidence fact sheet: adult mental health*. London: Royal College of Occupational Therapists, 2017. <https://www.rcot.co.uk/file/1805/download?token=dA7ez-G9>
- 4 Moll SE, Gewurtz RE, Krupa TM, et al. "Do-Live-Well": a Canadian framework for promoting occupation, health, and well-being. *Can J Occup Ther* 2015;82:9–23.
- 5 Heasman D, Morley M. Introducing prioritisation protocols to promote efficient and effective allocation of mental health occupational therapy resources. *Br J Occup Ther* 2012;75:522–6.
- 6 Disability Rights Commission. *Equal treatment: closing the gap: a formal investigation into the physical health inequalities experienced by people with learning disabilities and/or mental health problems*. London: DRC, 2006.
- 7 Northey A, Barnett F. Physical health parameters: comparison of people with severe mental illness with the general population. *Br J Occup Ther* 2012;75:100–5.
- 8 Chester P, Ehrlich C, Warburton L, et al. "What is the work of Recovery Oriented Practice? A systematic literature review". *Int J Ment Health Nurs* 2016;25:270–85.
- 9 Smith GP, Williams TM. From providing a service to being of service: advances in person-centred care in mental health. *Curr Opin Psychiatry* 2016;29:292–7.
- 10 Salyers MP, Zisman-Ilani Y. Shared Decision-Making and Self-Directed Care. In: Goldman HH, Frank R, Morrissey J, eds. *The Palgrave Handbook of American mental health policy*. Palgrave MacMillan, 2020: 197–228.
- 11 Department of Health. *The NHS quality, innovation, productivity and prevention challenge: an introduction for clinicians*. London: DH, 2010.
- 12 College of Occupational Therapists. *Quality and productivity. COT briefing 128*. London: COT, 2010.
- 13 Royal College of Psychiatrists. Accreditation for acute inpatient mental health services (AIMS), 2017. Available: [https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/aims/aims\\_wa\\_6th\\_edition\\_final\\_version\\_updated\\_september\\_2017.pdf](https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/aims/aims_wa_6th_edition_final_version_updated_september_2017.pdf) [Accessed 30 Jun 2022].
- 14 The Royal College of Psychiatrists. CCQI standards for inpatient mental health services, 2022. Available: CCQI Core Standards (rcpsych.ac.uk) [Accessed 30 Jun 2022].