South London and Maudsley NHS
NHS Foundation Trust

The Role of Housing in Delivering Rehabilitation & Recovery Outcomes Getting it Right First Time.

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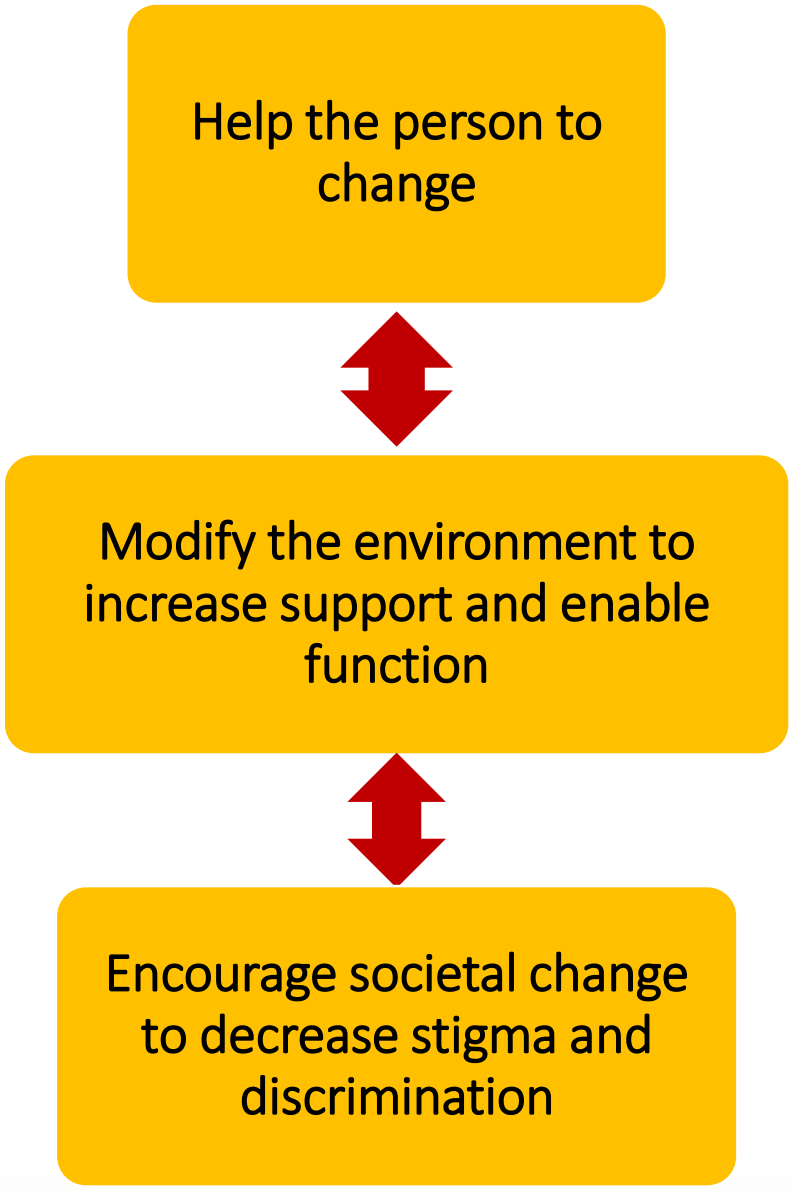
Mental Health Rehabilitation, NHSI&NHSE

GETTING IT RIGHT FIRST TIME

What is Psychiatric Rehabilitation & Recovery?

"A whole system approach to recovery from mental ill health which maximizes an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support."

(Killaspy et al, 2005)



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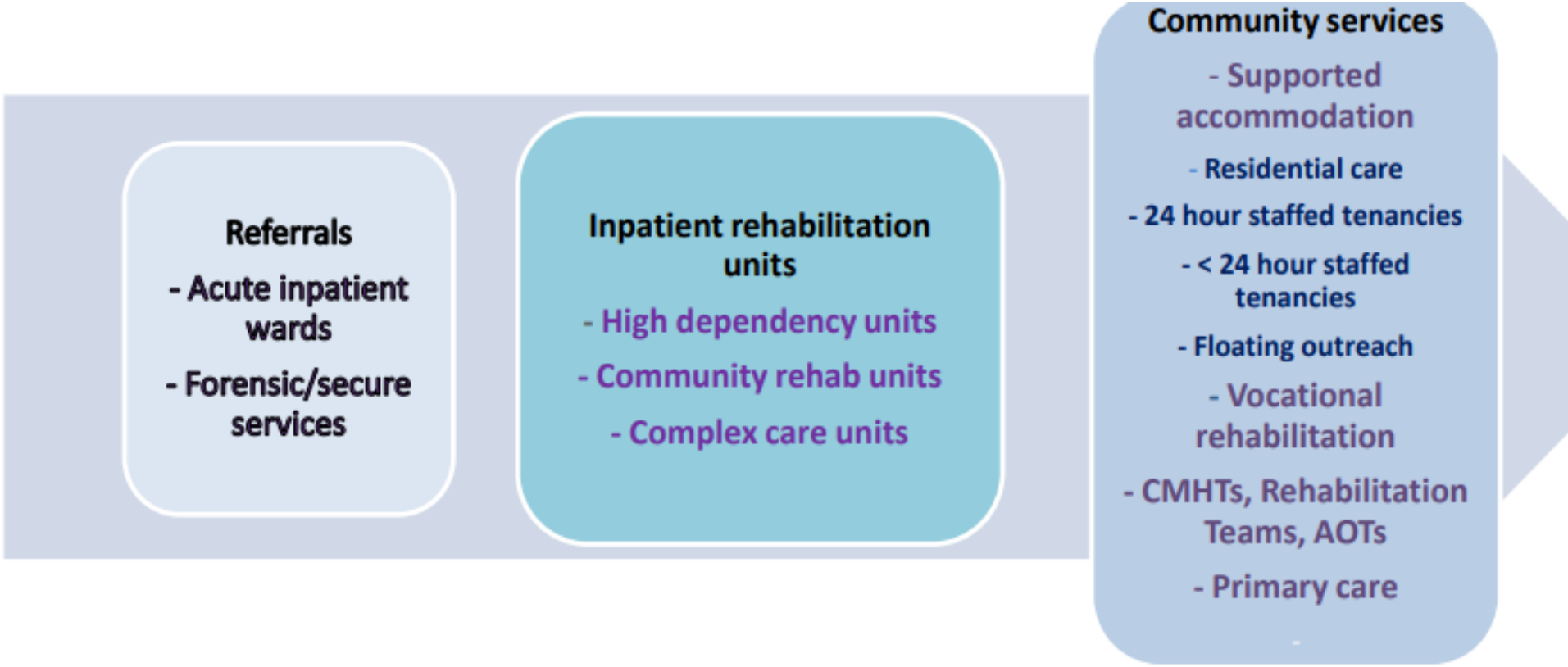
A whole system approach to mental health rehabilitation services



Rehabilitation Psychiatry

- 85% Psychosis – longer term conditions
- Treatment resistance
- Negative symptoms
- Comorbidities, psychiatric and physical health
- Functional impairments – Activities of Daily Living
- Challenging behaviour
- Difficult to engage
- Risk
- (Holloway, 2005)
- ~14% of EIP require rehabilitation; earlier transfer better
- Approx. 10-15% of those in secondary care, account for 25-40% of the annual UK mental health and social care budget (MH Strategies 2010 & Killaspy 2010)

The principles of rehab are relevant to all Mental Health services

Evidence for rehabilitation services

14% of people newly diagnosed with psychosis will require rehabilitation services (Craig et al, 2004)

Long term view/evidence: 65% of this group achieve successful, sustained community living over 5 years and 8% achieve independent living (Trieman and Leff, 2002; Killaspy and Zis, 2012)

Support from rehabilitation services: 8x ↑achieving /sustaining community living compared to generic CMHTs (Lavelle et al, 2011).

More evaluation data from recent publications – Bunyan, Killaspy, 2016

IN-PATIENT REHABILITATION: CLINICAL OUTCOMES AND COST IMPLICATIONS, BUNYAN ET AL, 2016

Table 1 Admission costs per year pre- and post-rehabilitation

	Pre-rehabilitation	Post-rehabilitation	Statistics
Individual cost, mean (s.e.)	£66 000 (£10 000)	£18 000 (£9000)	$t_{(21)} = 3.200$, $P = 0.004$
Total cost ($n = 22$)	£1 324 000	£386 000	

Consequences of disinvestment in mental health rehabilitation services

- ACUTE OAPS - Increased use of private beds for acute patients
- More revolving door & longer acute hospital admissions, for those with complex needs
- Supported housing pathway gets blocked (no move-through)
- Clinical iceberg in community of people with negative symptoms and treatment resistant symptoms
- People with complex needs become stuck on acute admission wards (delayed discharges)

Consequences of disinvestment in mental health rehabilitation services

Increased use of local low secure units

Increased use of Rehab OAPS - the "virtual asylum"

Use of forensic beds + Private hospital beds ("locked rehabilitation"/low secure)

Nursing/residential care beds

More expensive, poor rehabilitative culture, social dislocation

(Poole et al, 2002; Priebe et al., 2003; Killaspy , 2011)

IMPACT OF INSUFFICIENT REHABILITATION SERVICES ON OTHER PARTS OF THE MENTAL HEALTH SYSTEM

Acute Psychiatric Inpatient Delays(16% - Crisp Review)

Out of Area Placements – acute and Rehab; **Winterbourne**

Neglect in the community

Revolving door readmissions & Placement breakdowns

CQC report: The state of care in mental health services 2014 to 2017

- 3,500 people in 'locked rehab' settings. Cost approx 85 million / year across England
- Most are OATS and around 2/3 are in the private sector
- OATs are not good value
- Many MDTs are not sufficiently well trained in Rehabilitation, to provide high quality, intensive rehabilitation

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https://www.rcpsych.ac.uk/pdf/insightandinmind.pdf

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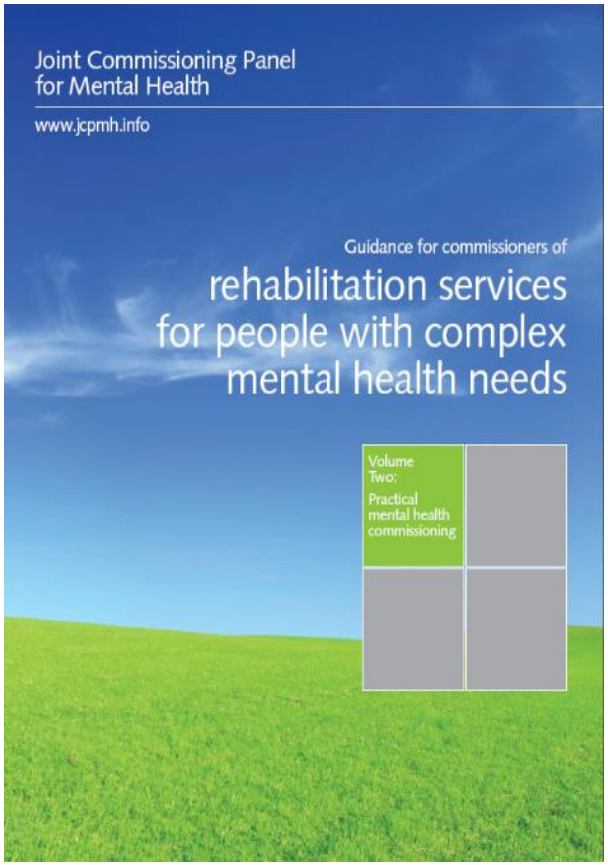
A National Strategy

National Commissioning Guidance

Rehab services continues to wax and wane around the country

NICE Guidance now underway



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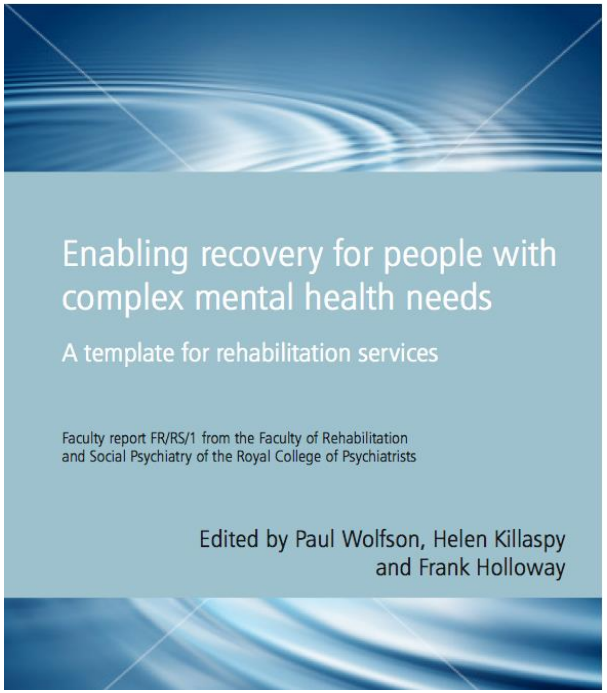
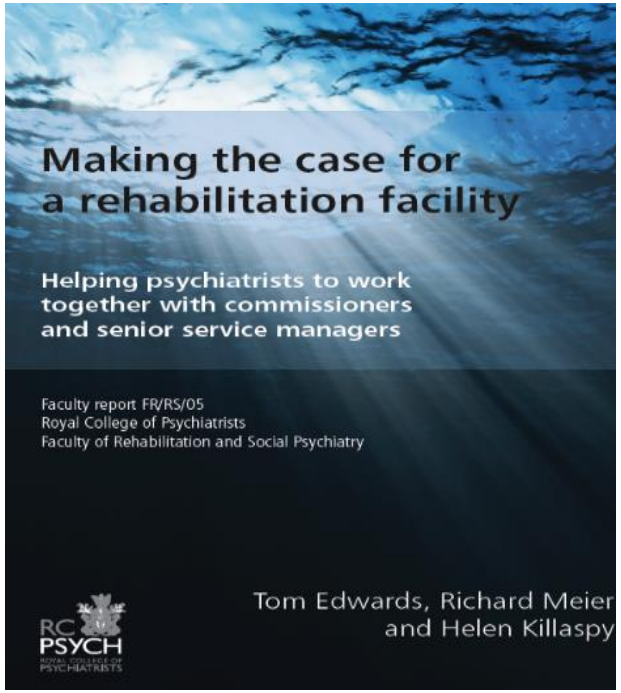
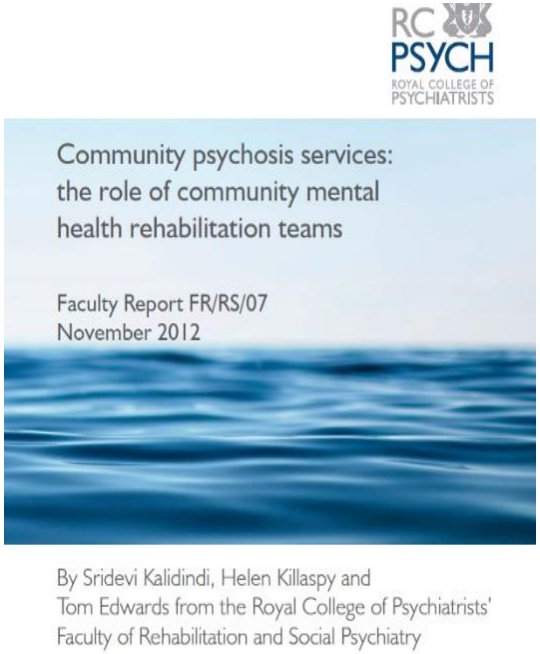
A National Strategy



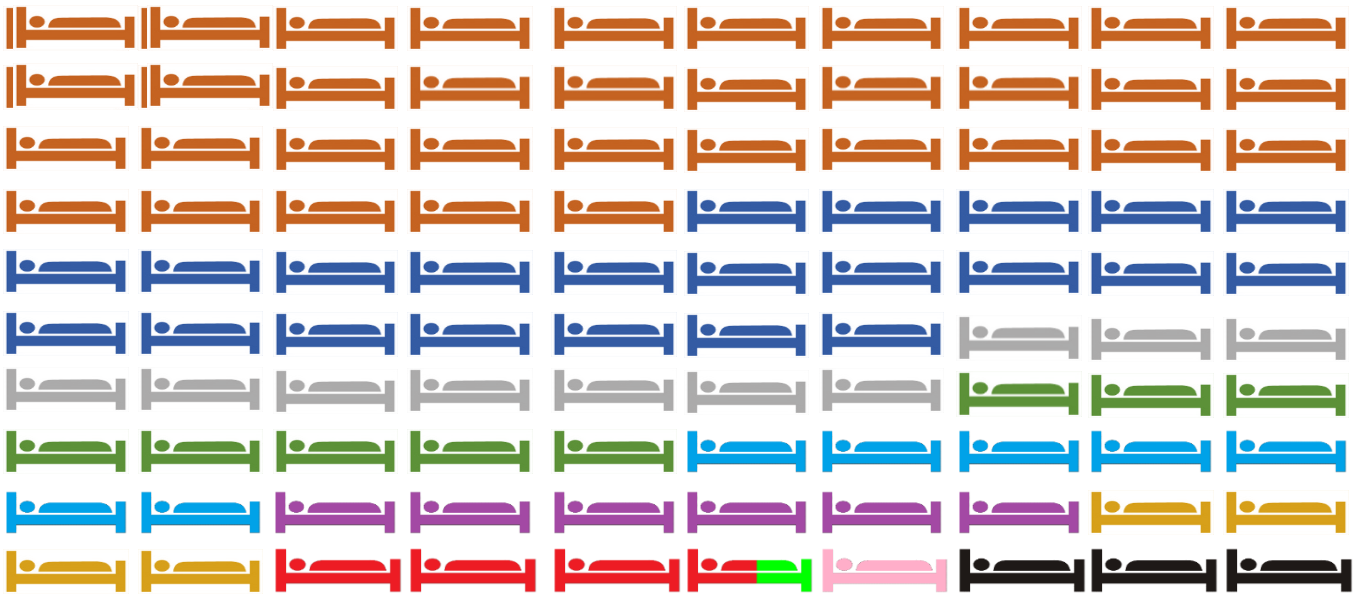




http://www.rcpsych.ac.uk/workinpsychiatry/faculties/rehabilitationandsocial.aspx

Community Rehabilitation Team' Functions

National beds % by specialty



Adult Acute (35%)
Older Adult (22%)
Medium Secure (10%)
Longer Term Complex / Continuing Care (8%)
Low Secure (7%)
High Dependency Rehab (6%)
PICU (4%)
High Secure (3.5%)
Mother and Baby (0.5%)
Eating Disorders (1%)
Other beds (3%)

Benchmarking Specialist Beds

Profiling average length of stay & workforce

Bed Type	Average length of stay (days)	Consultant Psychiatrist per 10 beds	Total Nursing per 10 beds
PICU	45	0.7	28
Low Secure	594	0.7	17
Medium Secure	548	0.7	20
High Secure	2,450	0.5	21
Eating Disorders	100	0.8	17
Mother and Baby	39	1.2	28
High dependency rehabilitation	409	0.3	14
Longer term complex / continuing care	760	0.3	14

Benchmarking Beds
Profiling inpatient costs

Bed Type	Average cost per admission £	Average cost per bed per annum £
Adult Acute	£11,300	£126,000
Older Adult	£32,000	£136,000
PICU	£37,000	£218,000
Low Secure	£346,000	£143,000
Medium Secure	£394,000	£172,000
Eating Disorders	£50,000	£160,000
Mother and Baby	£35,000	£199,000
High dependency rehabilitation	£194,000	£111,000
Longer term complex / continuing care	£435,000	£113,000

Benchmarking Community Services costs

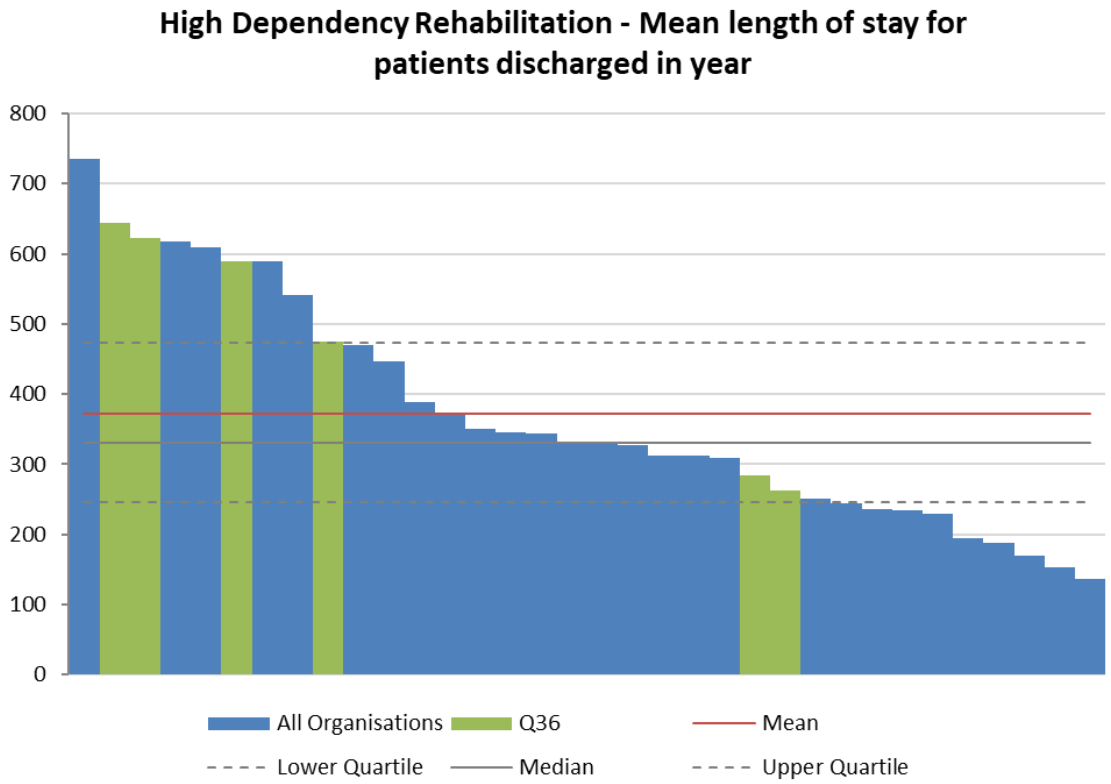
Profiling CMHT costs

CMHT Type	Average annual cost per service user on caseload £	Average cost per contact £
Generic CMHT	£2,977	£163
Crisis Resolution & Home Treatment		£184
Assertive Outreach	£9,157	£115
Early Intervention	£6,840	£201
Assessment & Brief Intervention		£248
Eating Disorders	£5,111	£463
Mother and Baby	£2,607	£179
Older People	£3,976	£227
Memory Services	£1,134	£183

Community Rehabilitation Team' Functions

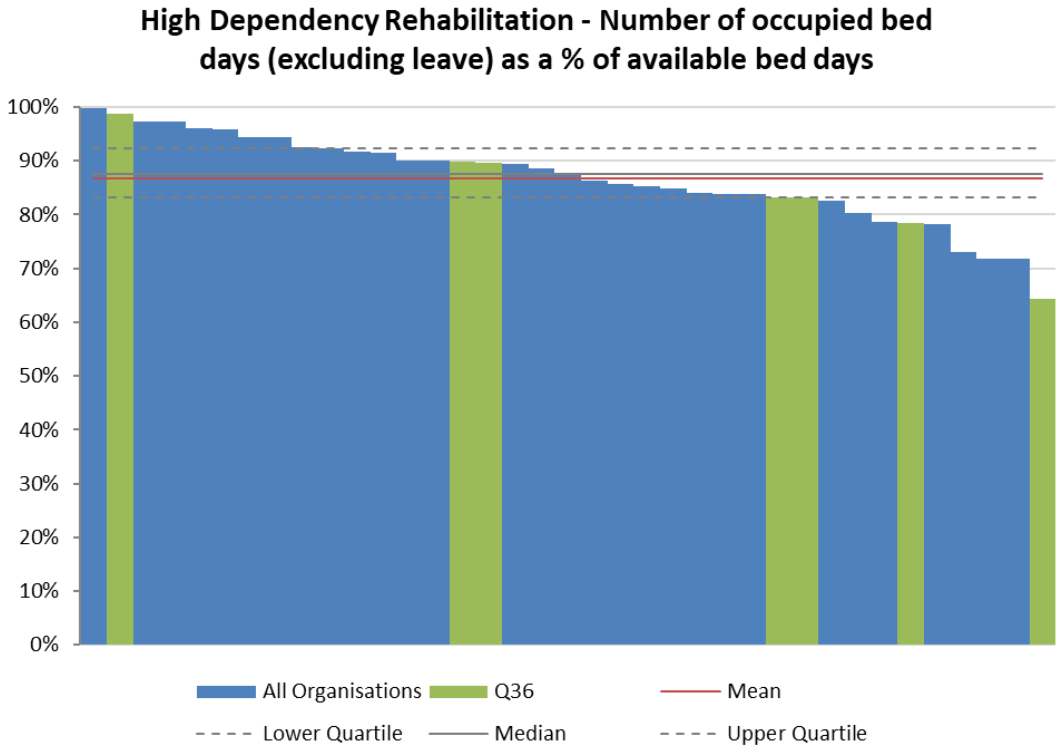
High Dependency Rehabilitation – Length of stay (2016-17)

- Average 372 days for patients discharge in year
- London peer group highlighted



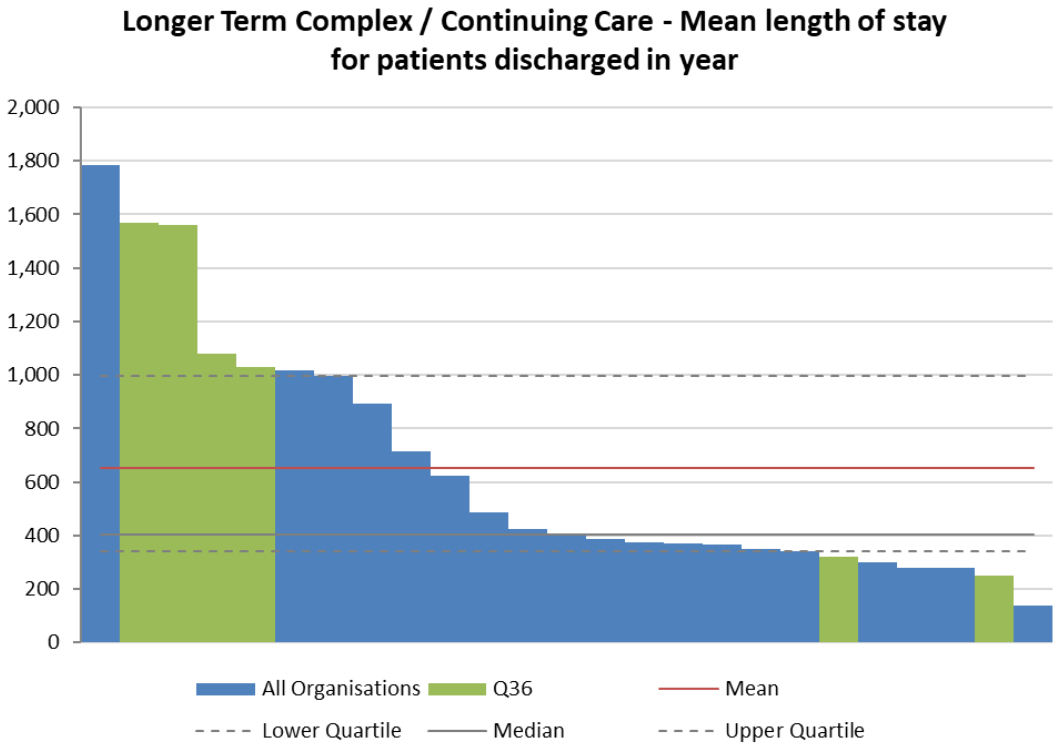
High Dependency Rehabilitation – Bed occupancy

- 87% average bed occupancy excluding leave
- Specialist beds report lower bed occupancy than acute admission beds



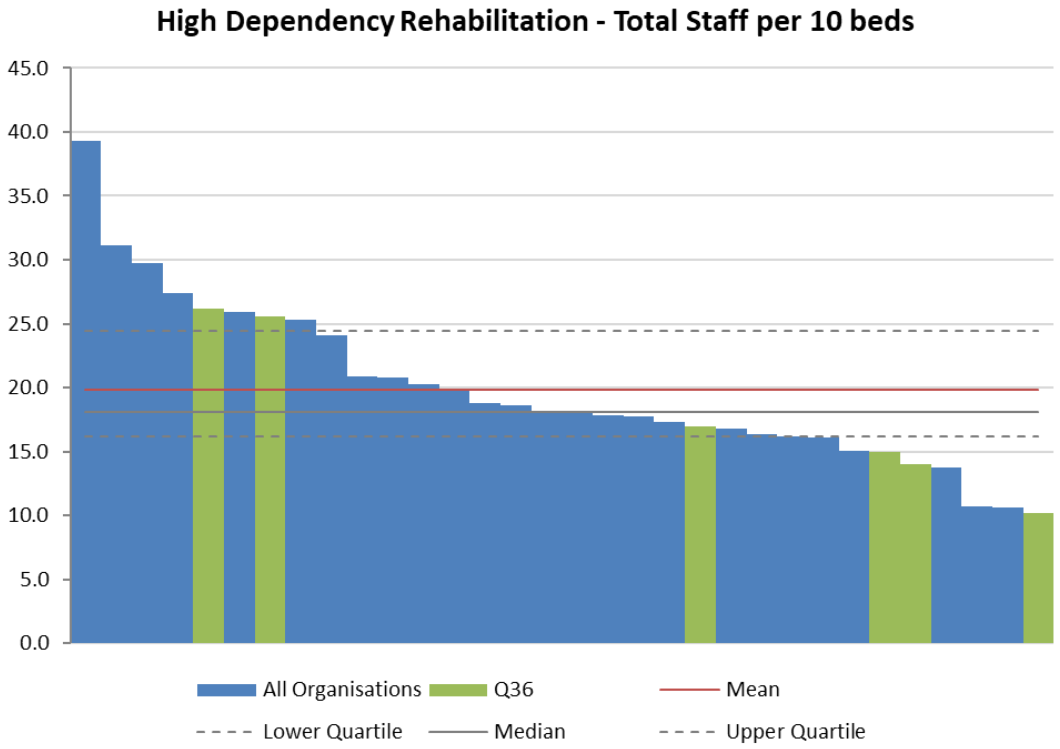
Long Term Complex Care – Length of stay

- Average 653 days for patients discharge in year
- London peer group highlighted



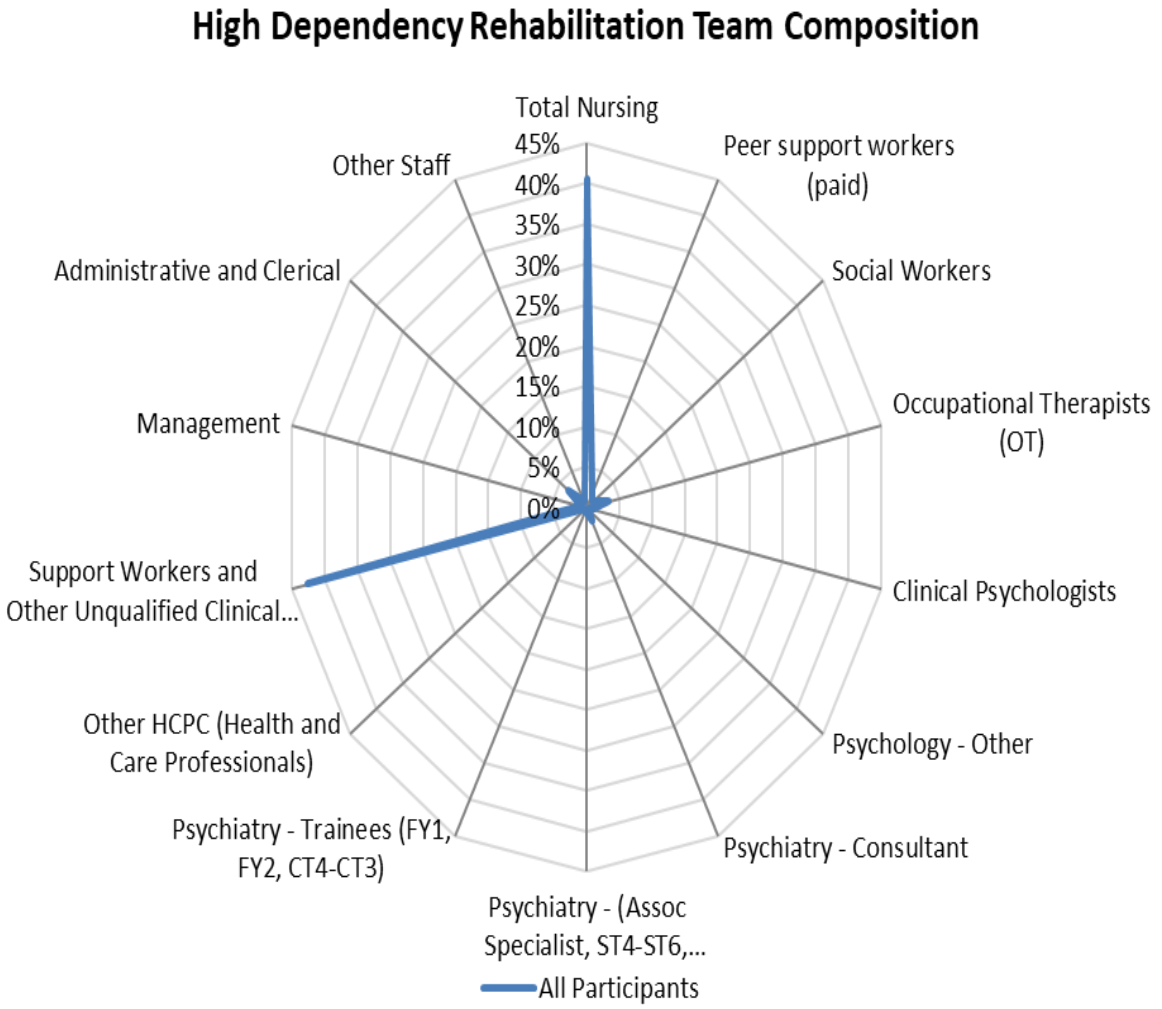
High Dependency Rehabilitation – workforce

- Average 19.8 WTE per 10 beds
- Includes clinical and non-clinical ward staff



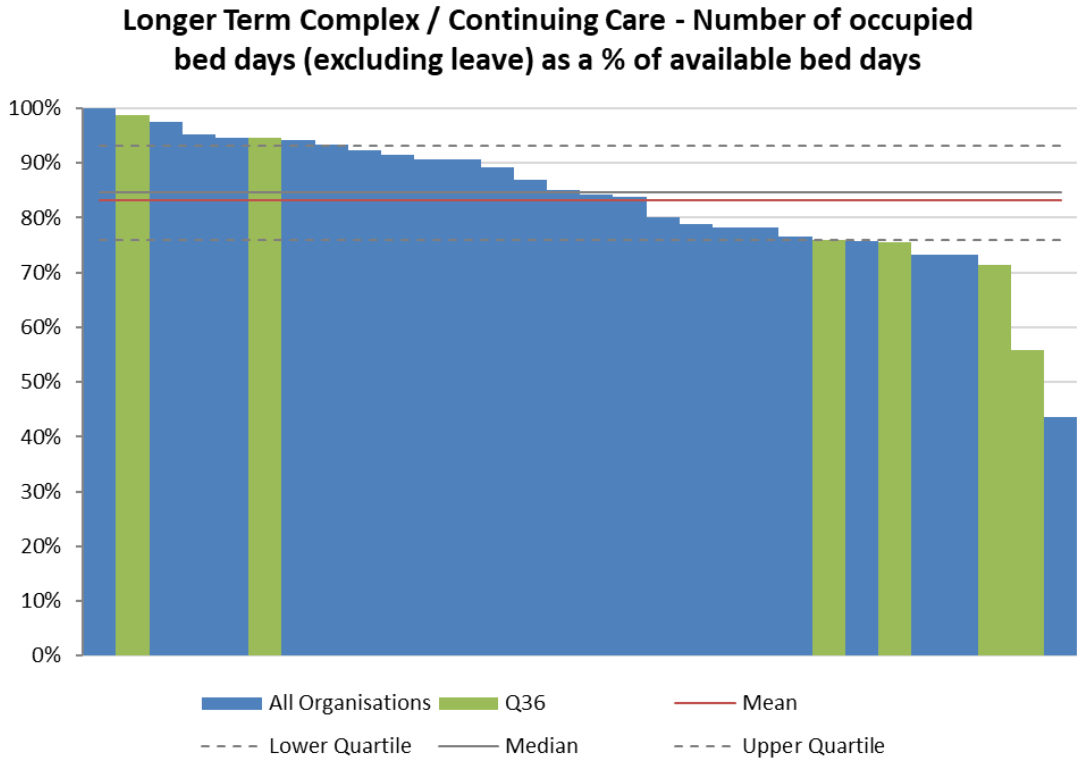
High Dependency Rehabilitation – Skill mix

- 41% registered nursing
- 43% support workers / HCAs
- 2% Consultant Psychiatry
- 1% Clinical Psychology
- 3% OT



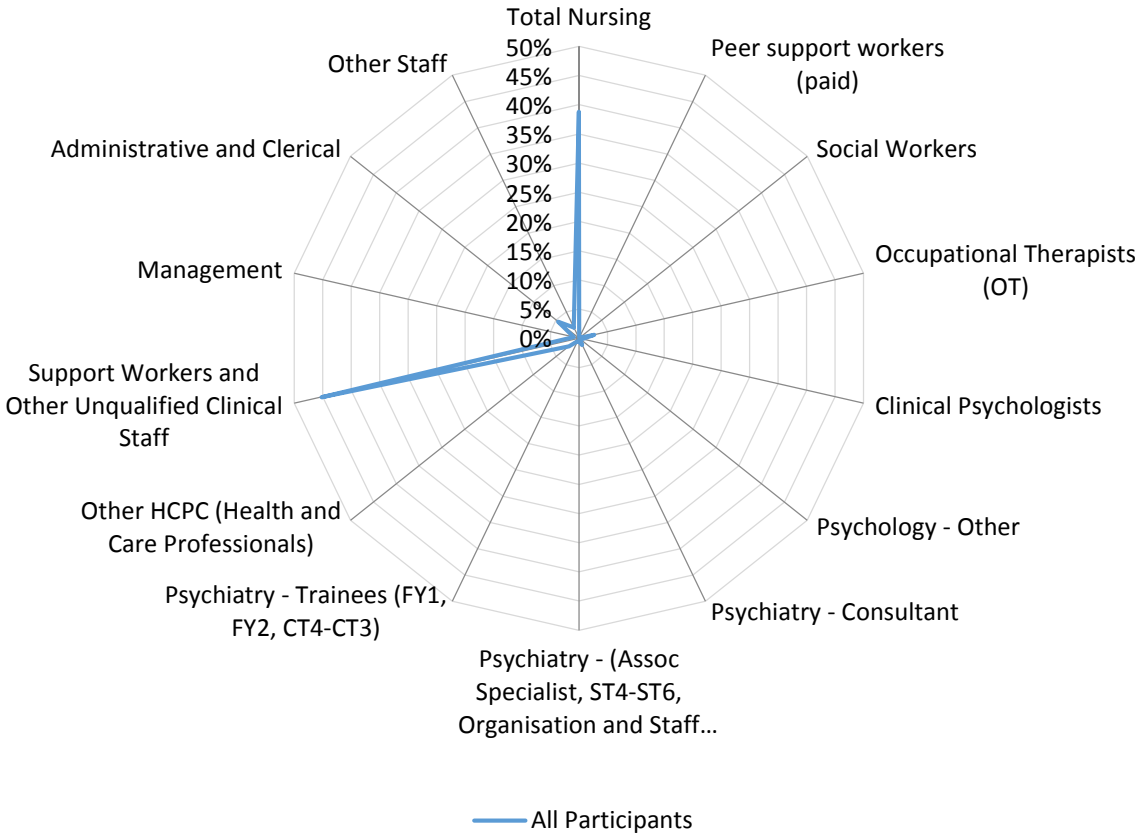
Long Term Complex Care – Bed occupancy

- 83% bed occupancy excluding leave
- Below the 85% maximum recommended by RCPsych, CQC etc.



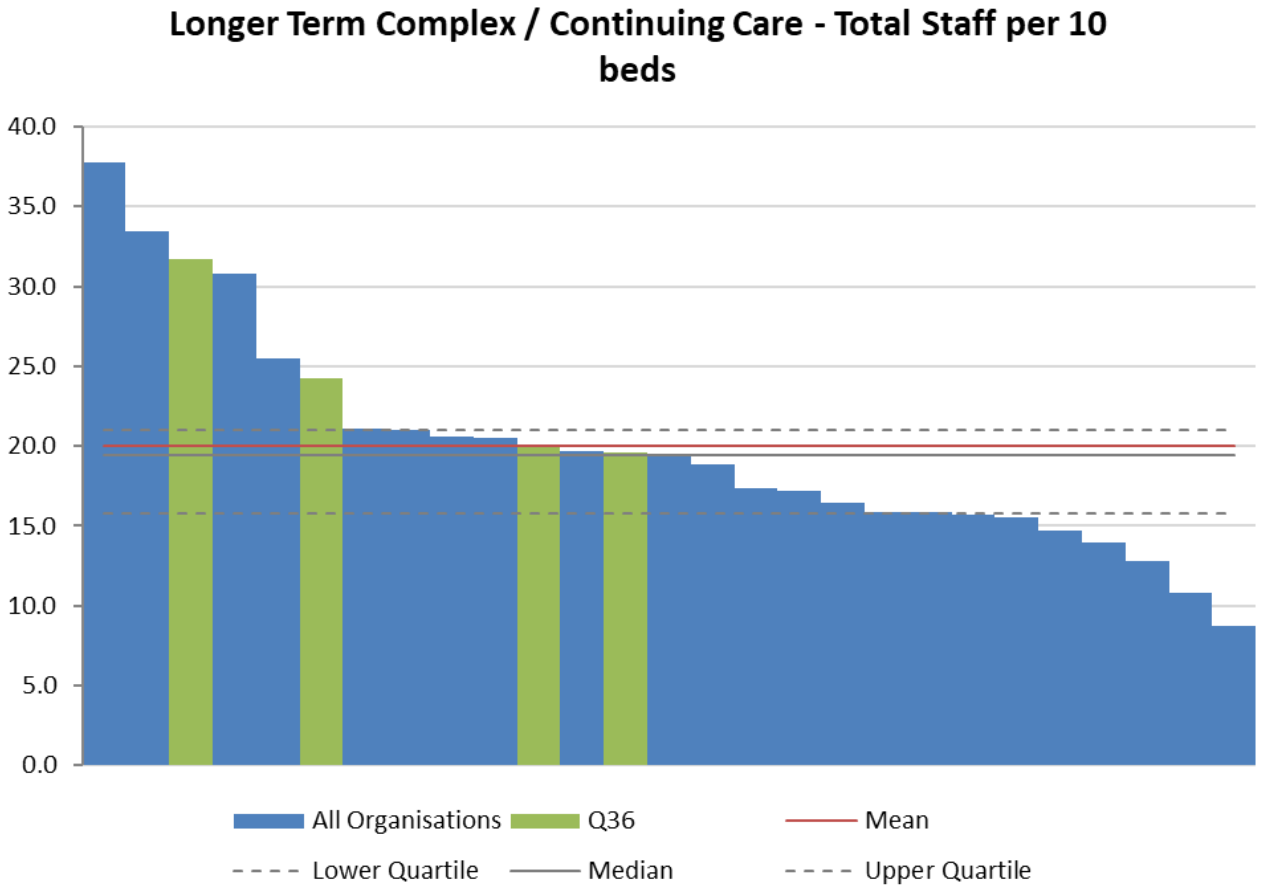
Long Term Complex Care – Skill mix

- 39% registered nursing
- 45% support workers / HCAs
- 1% Consultant Psychiatry
- 1% Clinical Psychology
- 3% OT



Long Term Complex Care – workforce

- Average 20 WTE per 10 beds



Benchmarking Network

Incidents

	Rates per 10,000 occupied bed days	
	Total Restraint	Prone Restraint
Adult Acute	108	20
Older Adults	79	3
PICU	428	99
Eating Disorders	58	1
Low Secure	127	8
Medium Secure	91	25
High Dependency Rehab	30	3
Longer Term Complex / Continuing Care	16	1

National average rates per 10,000 occupied bed days

	Volence to staff	Violence to other patients	Ligature incidents
Adult Acute	53	32	38
Older Adults	97	49	1
PICU	209	96	73
Eating Disorders	9	0	13
Low Secure	92	14	15
Medium Secure	32	14	12
High Dependency Rehab	17	11	13
Longer Term Complex / Continuing Care	23	11	1

MORTALITY GAP

In south east London

- 16 years for women
- 18 years for men

- Cause: Most deaths from physical health conditions CVD, Stroke
- Partly due to socio-demographic factors – health inequalities
- It is 'lethal discrimination' at worst, at best, failure to act on evidence

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Recognising housing as a mental health intervention

Centre for Mental Health

The provision of supported housing can...

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Getting It Right First Time

Clinically-led programme, reducing variation and improving outcomes

Mental Health Rehabilitation – Dr Sridevi Kalidindi

GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement

Introducing GIRFT

- Review of **35 clinical specialties** leading to national reports for each.
- Led by **frontline clinicians** who are expert in the areas they are reviewing.
- **Peer to peer engagement** helping clinicians to identify changes that will improve care and deliver efficiencies, and to design plans to implement those changes.
- Support across all trusts and STPs to drive **locally designed improvements** and to share best practice across the country.
- Agreed **efficiency savings**: c.£1.4bn per year by 2020-21, starting with between £240m and £420m in 2017-18.

Tackling unwarranted variation to improve quality of patient care while also identifying significant savings.

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From pilot to national programme

Identify and reduce unwarranted variation and improve the quality of patient outcomes.

35 programmes underway; 1300+ visits by clinical leads already

Process:

- Engagement - Set data requirements then collect data.
- Trust / CCG / LA – level analysis.
- Visits to every Trust / CCG / LA – develop an action plan.
- Regional implementation support.
- Share good practice.

Egs – Sheffield and NTW – Rehab OAPs reduction (NB capability & capacity in CMHTs and acute inpatients)

C&I – good pathway; Croydon (SLaM) – Community Rehab Team; CWP – Rehab acute inreach – reducing acute OAPs

- CQC outstanding Rehab inpatients

GIRFT outputs

- 35 National Reports on specialties co-badged by national bodies plus reports on cross-cutting clinical issues such as procurement, litigation and post surgical infection.
- A rich database of c.10,000 GIRFT metrics across all trusts and workstreams accessed via the NHSI Model Hospital.
- A focus on delivering sustainable solutions that become *business as usual* for the NHS through:
  - GIRFT changes embedded in national policy e.g. definitive treatments;
  - work with NICE and national specialist associations to drive best practice delivery;
  - using GIRFT to drive a culture of continuous improvement in trusts.

GIRFT Implementation

- The responsibility for designing and implementing any changes derived from GIRFT recommendations lies with **trusts and their partners** in each local health economy.
- Each trust has a board-level **GIRFT clinical champion** (normally Medical Director), and each clinical workstream will have a designated GIRFT lead.
- Over 80% of **GIRFT staff** are trust facing. Nearly 40% are clinicians. They support each trust and their local partners to improve clinical outcomes.
- **Clinical Leads**, as national leaders in their field**,** advise trusts on how to reduce any unwarranted variations seen in their GIRFT data packs and help to benchmark their performance against their peers.
- **Clinical Leads** drive improvement nationally by writing a GIRFT National Report on their specialty, through working closely with NHSE Clinical Directors, and by feeding into wider national improvement initiatives.

GIRFT local support

GIRFT Regional Hubs support trusts in delivering the Clinical Leads' recommendations by:

- Helping them to assess and overcome the local and national barriers to delivery.
- Working closely with NHSI regions to ensure prioritisation of GIRFT delivery takes account of the wider context within each trust and is joined up with local and regional improvement initiatives.
- Joining up with NHSE/RightCare to ensure integrated support for STP level improvements.
- Producing **good practice manuals** of case studies and best practice guidance that trusts can use to implement change locally.
- Supporting mentoring networks across trusts.

Each hub will have two **clinical ambassadors:** regionally recognised leaders of improvement programmes

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Partner Collaboration

The full potential of GIRFT can only be realised if the programme works in close partnership with a wide range of partners:

- There is a deep partnership in place between GIRFT and **NHSI Operational Productivity Directorate** to deliver joint objectives.
- GIRFT is working closely with **NHSI central teams** including including Medical, Nursing, Regulation, Strategy, Comms, Finance, Pricing and Patient Safety.
- GIRFT has agreed a joint operating model with the **NHSI Regional network**. GIRFT clinical ambassadors work closely with NHSI Regional medical directors and senior nurses.
- GIRFT is signing MOUs with **NHS England** RightCare & Elective Care Transformation Programme to offer a joined up approach to STP level improvements; and with Specialised Commissioning to jointly deliver improvements.
- GIRFT-**NICE** collaboration is included in its MOU with NHSI.
- **GIRFT** works closely with **Royal Colleges** and national professional associations on national reports, best practice guidance etc.

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GIRFT cross-cutting themes

- GIRFT is delivering 35 workstreams, occurring concurrently at different stages.
- Core focus is on peer to peer engagement within specialties, but to maximise improvement opportunities we also need to focus on patient pathways and services that cross specialty boundaries.
- GIRFT is therefore delivering a number of **cross cutting projects**:

- And GIRFT Clinical Leads are coming together to work in **clinical service lines** when beneficial for exploiting opportunities or joining up services across specialty boundaries:

GIRFT clinical impact

Quality Improvements:

A 4 year trend showing a marked decrease in therapeutic knee arthroscopies despite an increasing number of knee replacements, correlating strongly with the origins of the GIRFT programme.

It has benefited patients and saved resources.

Operational Improvements:

Eight trusts in three regions have reduced their length of stay for primary knee replacements following implementation of GIRFT recommendations, resulting in a collective saving of nearly £1m per annum.

GIRFT impact on resource savings

Orthopaedic pilot

c.£50m
savings over two years and improved quality of care

50,000
beds freed up annually by reduced length of stay for hip & knee operations

£4.4m
estimated savings p.a, from increased use of cemented hip replacements for over 65s

36%
reduction in litigation costs from 2013-16: a £77m saving

75%
of trusts have renegotiated the costs of implant stock and reduced use of expensive 'loan kit'

Case Study

One NW trust has made c.£700k resource savings between 2014 and 2017 through: cost effective procurement of specialist instruments (£133k), reduced length of stay (£364k), use of best practice tariff (£110k) and improved theatre utilisation (£74k).

Overall position to date

- GIRFT 2017-18 business plan target: £240m (£420m stretch target)
- Total savings opportunity realised in 2017-18 Q1 & Q2 is **£136m (57% of target**)
- Cumulative realised total to date (Q1 2016-17 to Q2 2017-18) is **£242m**

Note: figures are for gross notional savings. Actual figure is likely to be higher as not all metrics are currently measurable and greater benefits accrue as impact of recommendations land.

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Through all our efforts, local or national, we will strive to embody the ‘shoulder to shoulder’ ethos which has become GIRFT’s hallmark as we support clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.

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