



Efficiency in mental health services

Supporting improvements in the acute care pathway

Key points

- As part of the current focus on improving quality, innovation, productivity and prevention (QIPP), health economies are already examining where improvements in mental health services can be made.
- There is wide variation in bed usage in mental health.
- The data and questions set out here can provide a focus for discussions between PCTs, local authorities, emerging GP-led commissioning consortia and local mental health providers, to help identify improvement opportunities.

This *Briefing* is produced jointly by the NHS Confederation's Mental Health Network and Primary Care Trust Network, the Audit Commission, and the National Mental Health Development Unit. It provides a guide to support local mental health communities to gain a better understanding of their local acute care pathway for adult mental health and, where necessary, to help come up with solutions that provide better value for money.

It focuses on how organisations can use benchmarked data on bed usage, with additional local data where appropriate, to improve the efficiency of the acute care pathway. It has been designed for use in any mental health system, wherever they are on the performance scale and whatever their service configuration and their demographic and geographical circumstances.

Background

Over the next few years the NHS spending settlement will be flat in real terms. The NHS must achieve £15–20 billion efficiency savings by 2014 if it is to meet pay and price pressures and demand for services, invest in new technologies and interventions and continue to improve quality. Mental health

services, like all other areas of the NHS, will need to play a proportionate role in delivering these savings.

The NHS in England spends £6.311 billion per year on adult mental health services, £838 million of which is spent on clinical services, including acute inpatient care.¹

There is wide variation in bed usage across the country, even after adjusting for the needs of different populations. Analysis carried out by the Audit Commission illustrates significant variation in the levels of activity associated with the delivery of mental health services across the country, in terms of total bed days used, admissions and average lengths of stay. While some variation can be explained by population characteristics, other local factors such as differences in clinical practice and performance, as well as the level to which services are successfully integrated, are likely to contribute.

Understanding the reasons for this type of variation is important, and in the current financial climate many health economies will be asking whether it is possible to use resources more efficiently. In mental health, as in other areas

Defining the acute care pathway

There are a number of definitions of a care pathway. For the purposes of this *Briefing*, the starting point of the acute care pathway is when an individual is first referred to the crisis resolution and home treatment (CRHT) team. The end of the care pathway is defined as being when responsibility for the individual's care is transferred to another team, or when the individual is discharged from services after the acute phase or episode.

of healthcare, commissioners and providers are exploring opportunities to reduce the utilisation of inpatient facilities, while still providing safe and high, or even higher, quality care in their area.

The Audit Commission's analysis provides valuable insight into the national picture and enables local health economies to assess their relative position. This data is a starting point for further investigation into local services

with the practitioners and users who know them best. Reducing bed numbers is not an end in itself and this *Briefing* does not suggest a general target level of bed usage – there is no generic optimum length of stay. When applying the data and questions in this *Briefing*, commissioners and providers will need to be mindful that they take steps to maintain the quality of the service.

The data and questions can be used as a basis for a full review of

Reviewing the acute care pathway: a staged model

By taking a staged approach, the steps outlined here can be used as a basis for a full review of the acute care pathway.

Stage 1 – Diagnosis: National data can provide an initial overview of potential scope for improvements. The Audit Commission's analysis is summarised in this *Briefing*, along with key questions to ask. Commissioners and providers need to work together at a local level to explore in much more detail the facts behind the headline figures. Additional local data and information will aid a better understanding of their actual and relative position.

Stage 2 – Developing an action plan: Going beyond the data, stage 2 involves identifying solutions for improvement based on local analysis and discussion. Understanding the views of service users and how different parts of the mental health service work together, including where there are interdependencies, are critical in developing an effective action plan.

Stage 3 – Implementation: Effective data collection and tight performance assessment will be important at this stage to allow the local health economy to assess the effectiveness of the measures taken.

Post stage 3 – Ongoing improvement: It is important that the process of improvement does not stop at this point. Organisations may find it beneficial to come together on a local, regional or national basis, to compare implementation experiences, collaborate on developing joint solutions where there is mutual advantage, and to enable users to develop and improve the guide itself.

the acute care pathway – from identifying scope for improvement, through to action planning, to implementation and performance assessment, plus working with other organisations on commonly identified priorities.

The national picture

In 2010, the Audit Commission published information that illustrated the level of variation in bed usage across England.² That analysis was based on Hospital Episode Statistics (HES) data, including all inpatients coded to specialty 710 (adult mental health), and weighted according to population characteristics. The Audit Commission compared primary care trusts (PCTs), rather than providers, as population data is only available at PCT level.

There are a few caveats. Firstly, HES data does not differentiate bed types and includes activity in the following NHS inpatient facilities: acute, rehabilitation, psychiatric intensive care, and continuing care. The Audit Commission estimates that about 90 per cent of inpatient activity is acute (70 per cent) and rehabilitation (20 per cent).

Secondly, some PCTs are excluded from elements of this analysis because of poor data quality. For example, Figure 2 on page 4 illustrates variation for admissions with psychosis. A third of PCTs are excluded from this chart as over 25 per cent of the admissions for this group of PCTs had no specified diagnosis.

Thirdly, HES data does not routinely cover all types of providers. Mental health has

long been characterised by a mixed economy of provision from statutory, independent and third sectors. In any health economy, achieving efficiencies in the acute care pathway will involve commissioners and providers of all types working together. However, much of the national data available relates to statutory sector providers.

However, bearing these caveats in mind, the analysis remains powerful in that it illustrates high levels of variation between PCTs for which information is available, and highlights gaps in the data in other areas, where improved data recording and collection might be an initial priority.

Finally, it is recognised that current data sets for inpatient activity do not meet all clinical and management requirements. Data is not always specific enough to make appropriate distinctions between the different levels of need of service users. The development of payment by results in mental health should improve management information, as providers will be able to identify users by clusters. In future, the benchmarking of services using cluster data should provide a robust tool for driving further improvements in the acute care pathway.

Understanding variation

What are the factors that might explain variation?

Demographic factors explain some variation in bed days. The Audit Commission has adjusted the PCT populations to account for these

characteristics in the charts on page 4.

It was possible to attribute more of the variation to population factors for psychosis than for all admissions. 53 per cent of the variation in admissions for psychosis is explained by demographic factors, compared to 32 per cent for all admissions.

For all admissions, the population characteristics that have the strongest correlation with admission rates are living environment deprivation and health deprivation. For psychosis admissions, the population characteristics with the strongest correlation to admission rates are the percentage of the population who are black, and levels of employment deprivation.

After adjusting for population characteristics, there is still significant variation in inpatient activity, as is illustrated in Figures 1 to 6. Other factors that may influence that variation include:

- Different mixes of acute and rehabilitation facilities: HES data does not separately identify acute inpatient activity. As the ratio will vary from service to service, this may explain some of the variation. It is important for a local service to understand its particular 'bed mix' when developing its action plan.
- The level of service provision: those areas with relatively high numbers of beds may be likely to attract more admissions. Understanding use of out-of-area placements is also important.

• External factors: areas where health and social care are not particularly well integrated may have an impact on bed days, as you may expect higher numbers of service users to experience delayed discharges. Similarly, other local factors like the levels of homelessness and available

accommodation may impact on bed usage.

- Different, or changing, case mix and variations in the number of service users detained under the Mental Health Act.
- Different service models, clinical practice and performance.

Key issues to consider

National benchmarking data for PCTs, and, where available, for providers too, is a good place to begin when looking at the efficiency of local care pathways - many members will already be utilising such information. Ideally, this would be augmented

Audit Commission analysis of HES data²

Figure 1. Ten-fold variation in bed days for all admissions

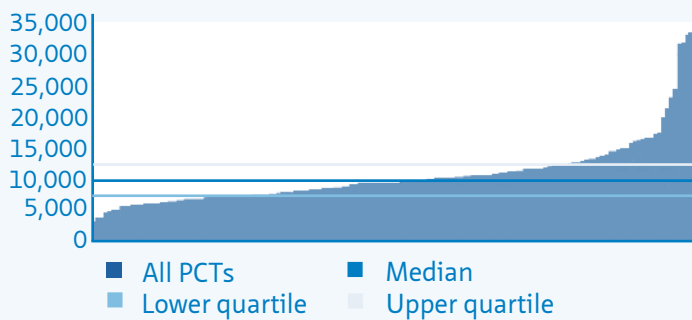


Figure 2. Ten-fold variation in bed days for admissions with a primary diagnosis of psychosis

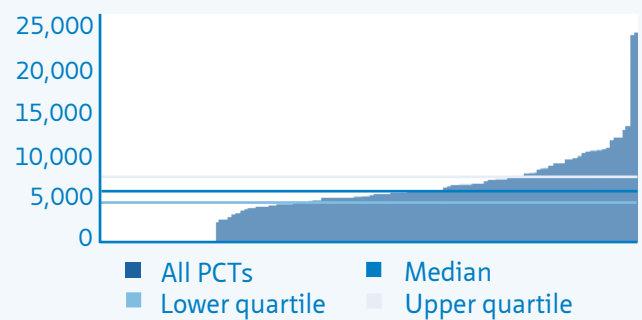


Figure 3. Admission rates for all admissions vary five-fold

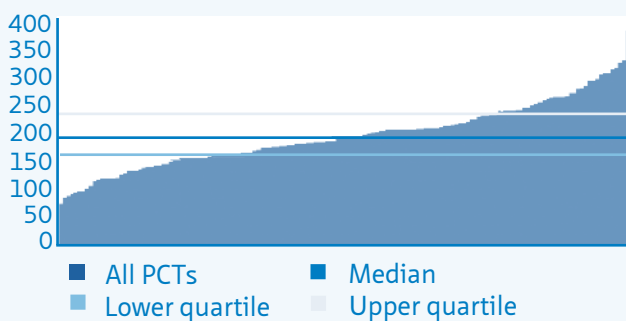


Figure 4. Admission rates for psychosis vary six-fold

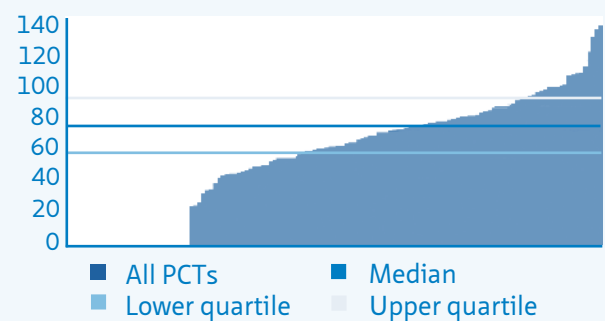


Figure 5: Length of stay for all admissions varies 11-fold

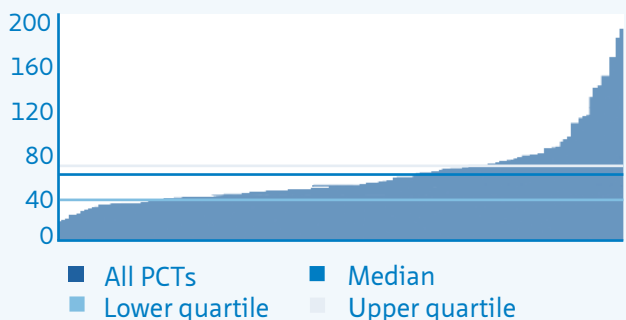
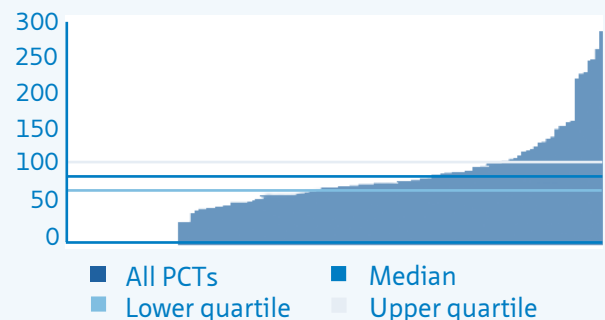


Figure 6. Length of stay for psychosis varies nine-fold



Do you know how you compare with others?

We have sent SHAs and PCTs individualised copies of the charts on page 4. If you would like an electronic copy of this data please email pctnetwork@nhsconfed.org

If you are a mental health provider, to receive a copy of the charts please email mentalhealthnetwork@nhsconfed.org, clearly stating which PCTs commission adult mental health services from your organisation.

with other relevant local data on bed usage, on crisis resolution and home treatment (CRHT) teams' activity, plus on available alternatives to admission.

A review of available evidence and current good practice (see page 7 for key references) suggest that the questions set out below can help reveal reasons for variance and help commissioners and providers improve efficiency.

Members will have no doubt already considered and asked many of these questions in the past, and will have a number of service improvement initiatives underway. However, different organisations will have focused on different issues and priorities depending on local circumstances. The list is designed to provide a starting point for further discussion, acting as a catalyst in helping to understand and act upon a number of different causes of variation.

Even if your own organisation already has a good grasp of these issues, there may be new individuals and groups in your area seeking to understand the mental health services they are, or will be, commissioning. These questions could be used to provide a focus and framework for discussions between mental health providers,

PCTs, local authorities, emerging GP-led commissioning consortia, and health and well-being boards, as they develop a common understanding of current mental health activity and performance, and agree plans for improving quality, efficiency and productivity.

Key questions

Evidence base

The Audit Commission analysis covers the following three areas:

- bed days per 100,000 of population
- admission rates per 100,000 of population
- average length of stay.

Q1) Where does our mental health economy feature according to the benchmarking data?

- a. What factors explain that position?
- b. Is our variation in performance significant enough to merit further investigation?
- c. What extra data does the local mental health community need in order to help understand variation? For example, levels of staffing in community teams (early intervention and community mental health

teams as well as CRHTs) and case mix.

The following questions relate to other factors that could help explain variation and sub-optimal performance.

System integration

Q2) Are effective links in place between teams, across all sectors, involved in admission and discharge from inpatient services (including CRHTs) to ensure:

- a. appropriate admission?
- b. the right care in the right setting delivered as quickly as possible?
- c. effective discharge without delays, including appropriate attention to situation reports detailing delayed discharges?

(Note: The 2007 NAO report, *Helping people through mental health crisis*, found that CRHT staff had only been involved in 53 per cent of its sample of admissions, and had had a bearing on the decision to admit in only 46 per cent of cases. Yet the report found evidence that, where CRHTs acted as a gatekeeper for inpatient services, admissions were lower.)

Q3) Are those staff who refer to CRHTs fully briefed on the role and purpose of the teams, and do effective arrangements exist for working across teams and organisations, including those in social care and housing?

(Note: The same NAO report found that other health professionals making referrals to acute mental health services could have better awareness and understanding of how the community and inpatient elements of an acute service

operate, which would make the user's route through such services more efficient.)

Q4) Are there clear and, where appropriate, common operational policies in place to ensure clarity of roles and responsibilities between different teams and different parts of the service involved in the care pathway?

Q5) Is there a single acute care pathway that is accepted and well understood by all parts of the service and other stakeholders?

User experience

Q6) How do local CQC user satisfaction scores compare with national findings? What do local surveys tell you about the quality of the inpatient experience? Are you measuring changes in user satisfaction alongside action to improve bed usage?

Q7) Do inpatient services use accredited schemes such as the Royal College of Psychiatrists' Accreditation for Inpatient Mental Health Services? If not, why not?

Q8) What steps are taken to help service users develop personal crisis plans to help keep people out of hospital, including the involvement of other agencies such as housing? What support is provided to carers to help people stay at home where appropriate?

Leadership and governance

Q9) Are clear leadership arrangements in place – including clinical leadership – to ensure prompt and effective decisions on pathway development?

Q10) Is there a named service lead responsible for championing and

leading care pathway development and overseeing the implementation of changes and improvements?

Q11) Is there a clear and explicit link between the governance of the care pathway and broader local care governance systems including housing, employment and community sector support?

Workforce

Q12) How do staffing levels and skill mix compare with other organisations and within the organisation? Where there is evidence to support optimal staffing and skill mix levels, are these being implemented effectively?

Q13) Have training and supervision needs identified during process mapping been acted upon?

Q14) Are effective arrangements in place for the continuing professional development and training of all staff, across all agencies involved, to ensure that pathway management is optimised?

Opportunities for innovation

Q15) Are there effective arrangements in place for staff to contribute to innovation and make suggestions for improvement in the pathway?

Q16) Has a process mapping exercise or similar methodology been undertaken at the early stages of care pathway development?

Q17) Are effective audit systems in place to encourage an evidence-based approach to improvement and the early uptake of innovation? For example, has the NHS Institute's Productive Mental Health Ward programme been introduced? If not, why not?

Q18) Does the service take on board national and international developments in inpatient care?

Staff and stakeholder involvement

Q19) Is there effective clinical and broader professional and stakeholder involvement in the process of pathway management to ensure effective decision-making both collectively and in individual cases?

Q20) Is information effectively shared across organisations, and at different levels, to ensure that all staff have the opportunity to support performance improvement? Is there a policy or protocol for ensuring awareness, education and involvement of all stakeholders in care pathway development? For example, is information on team variations in bed use, length of stay and other contributing indicators fed back to clinicians for reflective continuing professional development (CPD) practice?

Performance management

Q21) Are effective performance assessment and management arrangements in place across the whole care pathway to allow a broad understanding of performance levels and to inform action for further improvement?

Confederation viewpoint

The scale of savings that the NHS will need to make in the forthcoming period will be undoubtedly challenging. Improving both quality and productivity will require doing things differently. Redesigning services, in mental health, as elsewhere in the health service, will be key in achieving the level of savings required.

We would very much like to hear from commissioners and providers about their plans and strategies for improving efficiency within the acute care pathway. If you would be willing to share any examples, or for more information on the issues covered in this *Briefing*, please contact rebecca.cotton@nhsconfed.org

References

1. *2009/10 National Survey of Investment in Adult Mental Health Services*, Mental Health Strategies (MHS) for Department of Health, July 2010. Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117488
2. *Maximising resources in adult mental health*, Audit Commission, June 2010. Available at www.audit-commission.gov.uk/SiteCollectionDocuments/Downloads/20100623mentalhealthbriefing.pdf

Acknowledgements

With thanks to Dr Michele Hampson, Dr Geraldine Strathdee, Catherine Mitchell, Peter Horn, Jim Symington, Andrew van Doorn, David Daniel, Dean Repper, Diane Woods, Margaret Oates and Panos Zerdevas for their help in developing this *Briefing*.

Further reading

Helping people through mental health crisis: The role of crisis resolution and home treatment services, National Audit Office, 2007.

Mental health and the productivity challenge: improving quality and value for money, The King's Fund and Centre for Mental Health, 2010.

The pathway to recovery: a review of NHS acute inpatient mental health services, Healthcare Commission, 2008.

Integrated care pathways for mental health, NHS Quality Improvement Scotland, 2007.

The Mental Health Network

The Mental Health Network was established as part of the NHS Confederation to provide a distinct voice for mental health and learning disability service providers. We aim to improve the system for the public, patients and staff by raising the profile of mental health issues and increasing the influence of mental health and disability providers.

For further details about the work of the Mental Health Network, please visit www.nhsconfed.org/mhn or email mentalhealthnetwork@nhsconfed.org

The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs. We aim to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

For further details about the work of the Primary Care Trust Network, please visit www.nhsconfed.org/pctn or email pctnetwork@nhsconfed.org

The Audit Commission

The Audit Commission is an independent watchdog, driving economy, efficiency and effectiveness in local public services to deliver better outcomes for everyone.

For further details about the work of the Audit Commission and how we can help, please visit www.audit-commission.gov.uk or email ma-bruce@audit-commission.gov.uk or p-finn@audit-commission.gov.uk

National Mental Health Development Unit

The NMH DU provides national support for implementing mental health policy by advising on national and international best practice to improve mental health and mental health services.

For further details about the work of the NMH DU, visit www.nmhdu.org.uk

Further copies or alternative formats can be requested from:
Tel 0870 444 5841 Email publications@nhsconfed.org
or visit www.nhsconfed.org/publications

© The NHS Confederation 2011. The use of this publication is covered by the conditions of Creative Commons Attribution-Non-Commercial-No Derivative Works License: www.creativecommons.org/licenses/by-nc-nd/2.0/uk

You may copy or distribute this work, but you must give the author credit, you may not use it for commercial purposes, and you may not alter, transform or build upon this work.

Registered Charity no: 1090329

Stock code: BRI021401

NHS CONFEDERATION

The NHS Confederation
29 Bressenden Place London SW1E 5DD
Tel 020 7074 3200 Fax 0844 774 4319
Email enquiries@nhsconfed.org
www.nhsconfed.org

