Cheshire and Wirral Partnership NHS
NHS Foundation Trust

A Zero Harm approach to the English Mental Health Bed Crisis

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STOP THINK LISTEN

#CWPZeroHarm

STOP: don't rush in

THINK: weigh up the risk, benefits and options

LISTEN: hear the views of other staff, people who use our services and carers.

Zero Harm Strategy- The initial three year programme through to 2017 includes annual review. Year one (reported 2014) involved visiting and listening, human factors training, appointment of key staff including Care Programme Lead, Locality data analysts, CRAC team and identifying priorities. We are creating a culture of celebrating improvement e.g. through the Big Book of Best Practice. We know that not everything goes as planned and we are learning to celebrate failure as well as success as long as both are fed into the rolling programme with iterative development using PDSA cycles.

Update: This poster updates long term progress regarding the Zero Harm Strategy. In Paris 2014 we presented the Zero Harm campaign using an example of improved Trust clinical risk assessment summary (CARSO) leading to improvement from less than 10% to over 90% (target 85%). This has been sustained and in 2016 is over 97%. In London 2015 we used the example of Complex Recovery Assessment and Consultation (CRAC) service bringing complex out of area cases back into sight and mind and delivering the IHI triple aim through this work. The work we are focussing on here relates to the acute inpatient care pathway.

Paris 2014

London 2015

National context

The economic realities in England have led to significant reductions in available public funding. The NHS has been relatively spared but has had to make large efficiencies to stay within budget. Nationally 1 in 7 acute admissions now go out of area increasing risk of harm. Mental Health Act detentions nationally rose 10%.

In National Benchmarking CWP has one of lowest incomes and fewest beds per weighted head of population.

CWP has periodically reduced beds since 2005 to maximise resources available for community expenditure to above national average (58%). This has been against rising pressures on inpatient beds nationally. For the population of 1 million spread over 600 square miles in 2011 CWP used 169 acute beds. By 2012 it was using 181. A bed utilisation review identified a number of issues including that cases that could not be quickly discharged as were too complex tended to drift. CRAC was set up to help address this (as well as to improve oversight and input to out of area complex inpatients). This was done by enhancing the care bundle in the acute care pathway at 40 days including a full review. By 2013/4 bed usage was down to 138 beds, 2014/5 149, but by November 2015 this had increased to 165. The increase was due to a year on year rise in admissions (1577 to 1580 to 1611) with increased complexity including greater number of detentions under MHA 1983. Meanwhile delayed transfers of care fell from 1148 days to 423 to 386. Therefore, we were already operating at efficiency levels above the English average but experiencing the same cost and demand drivers and worrying trends were appearing.

Intervention: Each ward team designed specific reports to help them understand the issues and opportunities for them. Review of admission and discharge systems, escalation policies for risk, alongside listening to perceptions facilitated synergistic use of qualitative and quantitative data. The CRAC team helped to shift locus of control back to the interface between people accessing the service and those providing it not imposed from above. It helped staff to understand that with a fixed total pot of resource moving people to expensive far away options might temporarily ease ward pressure but ultimately reduce available local resources. Staff were encouraged to think about what "good looks like" and to praise staff for delivering good, not blaming them for lack of perfection. This in turn allowed better and more open discussion of what was wrong or needed fixing. Reinforcing that care plans coproduced to take account of the individual's strengths, needs and aspirations need to be dynamic not form filling exercises.

Outcomes:

The acute number sent out of area for CWP from 2002- 2014 was zero.

In 2014 there were 10 out of 1683 admissions i.e. 0.59% compared to national average figure of 1:7 which is 14.2%.

The number of bed days involved was 29 out of 57802 (0.05%). CWP managed to get those out of area back very quickly.

CWP gets below average income but has:

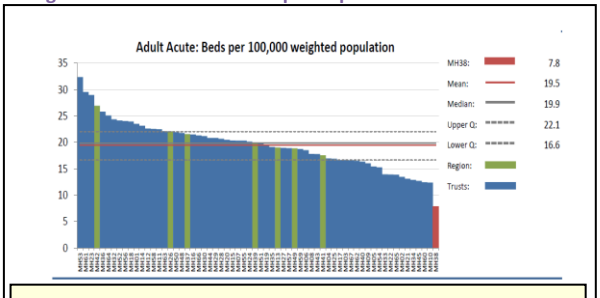
*** rated top in national Mental Health community satisfaction score.**

*** been given CQC overall accreditation of "good" with "outstanding" for care element so well above national average.**

*** "good" in national benchmarking for openness and honesty - well above national average (67 out of 220)**

*** In HSJ top 100 best places to work**

In December 2015 CWP stopped, thought and listened and recognised that despite all mitigations bed occupancy trends are rising so further work has now put in place to address this.



The above table has been taken from the 2015 Mental Health Benchmarking report, published by the NHS benchmarking network. MH38 is CWP.

Care • Well-being • Partnership

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