Review into the Operational Productivity of Mental Health and Community Services

• Lyn McIntyre MBE, Mental Health Senior Adviser, NHS Improvement – a focus on rostering and CHPPD

• Ros Alstead OBE, Director of Nursing & Clinical Standards, Oxford Health NHS Foundation Trust – a view from a trust

• Andrew Edmunds, Senior Implementation Lead – Approach and Emerging Findings
Inpatient workforce productivity

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Work stream overview

Review work includes:

• **Care Hours Per Patient Day (CHPPD)** data collection

• 90-day rapid improvement collaborative programme with cohort trusts

• **Review of practices and policies** to support inpatient rostering
Care Hour Per Patient Day - CHPPD

• Care hours per patient day – CHPPD is a simple calculation by dividing the number of nursing hours available by the numbers of patients

• It therefore represents the number of nursing hours that are available to patients

• It provides a measurement that enables units of a similar size and patient group to be benchmarked

• Assesses the utilisation of nursing resources on a daily, weekly, monthly basis, identifying areas for further scrutiny

Cohort data collection

• Collected 1 month of nursing data from all inpatient units in the cohort during Feb / Mar 2017

• Telecalls in May 2017 to achieve deeper understanding of the outliers, identify possible good practice models and examine associated outcomes.

• Data informed 90-day rapid improvement collaborative to:
  – Assess scope for efficiency improvements & improvement pathways
  – Pilot improvement models in pathfinder trusts
  – Support national data collection methodology

National data collection

• Purpose is to build on early findings and approach with cohort to support all trusts

• National data collected in September 2017. Telecalls taking place now.

• Included AHPs
Ward level CHPPD example – understanding AHPs contribution
Ward level CHPPD example
Collaborative overview

• 90-day Rapid Improvement collaborative, focussed on rostering practices and policies.

• 24 trusts visited, re-visits booked for November/December

• Many miles travelled! Over 5,500 miles…

• Great way to find out how trusts are doing, focus improvement activity, capture good practice and share the learning
Areas of focus

Approval of roster  7
Unused hours      5
Unavailability    4
Bank and agency   4
Auto roster       2
Additional hours  1
AHPs              1
Key themes from the visits

• Use of the rostering data
• Use of headroom
• Auto-roster
• Flexible working
• Communication and policies
• Roster team and champions
• Sustaining change
Main themes: Roster policy

• All 24 Rostering Policies review in line with national guidance
• Letters sent to each trust with suggested updates
• Most were:
  – Headroom and specific KPIs
  – Regular audit of use of policy
  – Rules for changing shifts
  – Overall principles for policy
  – Linking to other relevant policies for consistency
Next steps

- Trusts will continue to work on their improvement goals until 31 January 2018 with support from NHS Improvement and the regional teams.

- The November 2017 learning session will focus on tracking their improvement with the data trusts are collecting monthly, mapping the financial savings each trust expects to make, based on progress to date and scale and spread.

- Guidance documents supported by case studies will be developed and shared across all mental health and community trusts in March 2018 for each improvement area highlighted in section 5.
Floor to Board Reporting

Oxford Health’s 90 Day Improvement Challenge
Our Approach – Leadership and Implementation

- Nursing
- Finance
- Workforce
- Ops
Our Progress before Carter

- Allocate HealthRoster purchased in April 2015
- 40% of AfC staff are on the system
- SafeCare Live currently being implemented
- Insight recently purchased
- All Agency spend on system
- Many benefits have been realised

……..but there is room for improvement!
Our Carter challenge

• To develop a floor to board rostering reporting and review process - provides focus enabling the Trust to improve rostering practice.

• First area for improvement identified as roster building and approval process.
  • Improve roster scrutiny and approval process
  • Increase roster publication times
  • Improve lead times shifts are sent to bank

• Scope – all areas on the system split by:
  – Inpatient Units
  – Other teams
Floor to Board Review

- Priorities proposed by Operations Management team and owned by Exec
- Information flow cascades up and down
- Created rosters reviewed and challenged by peer group prior to publication at meeting
- KPIs for previous roster period reviewed and actions agreed

Meet 4 weekly when rosters due for approval and Insight data available in existing meetings
Implementation Plan

Engagement

Develop Guides & Checklists

Coaching

Roster Period Reporting Pack

Roster Review Go live

Development of Demand and Budget setting Review Process

Caring, safe and excellent
Budget Setting

• It is vital that budget information in the rostering system is accurate to enable us to report on the difference between:
  – Budgeted staff and contracted staff (vacancies)
  – Planned and actual staffing used
  – The indicative cost of the staffing being used and variance to budget
  – The reasons for changes to staffing requirements

• Challenges:
  – Staff on rosters do not always match cost codes
  – Skill mix and staffing requirements change frequently
  – Keeping 3 systems accurate – ESR, finance, rostering
Progress to Date

Work So far:

✓ Operations Management Team review Key Rostering KPIs monthly
✓ Work on improving roster publication and lead time shifts sent to bank effective from rosters commencing 4 December
✓ Formal roster review meetings set up for rosters published 20 November
✓ Roster review work commenced in community teams
✓ Budget setting process commences 4 December
Next Steps

• Deep dive roster reviews with 3 units to identify if further benefits can be achieved

• Continue to drive through improvements with Roster publication and shifts sent to bank lead times

• Embed review and challenge process at all levels and ensure it is working effectively

Then....

• Move to business as usual and next area for improvement - Unavailability
Approach and Emerging Findings

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Approach

1. Understanding how organisations in mental health and community trusts operate
2. Understanding what good looks like
3. Defining and capturing information and benchmarks
4. Establishing improvement opportunities

Initial phase has been to work with a cohort or 23 trusts
Linking our starting point and approach

**Approach**

1. Understanding how organisations in mental health and community trusts operate
2. Understanding what good looks like
3. Defining and capturing information and benchmarks
4. Establishing the opportunities for improvement

**Starting point**

- Complex system and highly fragmented provision
- Limited outcome data and national standards
- No consistent service line definitions and specifications

Focus on engagement and primary data capture

Establishing the opportunities for improvement?
Key areas of focus

Focus of our initial data capture and analysis has been on four core areas:

- Core service line data
- Care Hours per Patient Day
- Productivity of community services
- Enablers: estates, procurement and corporate services

We have identified variation and we think there is significant **unwarranted variation** and scope for making savings in key areas.
### Care Hours Per Patient Day

#### Table showing average by Staff Group

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Total Hours</th>
<th>Total CHPPD</th>
<th>Substantive</th>
<th>Bank</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Support Worker / Nursing Support (Unregistered)</td>
<td>989,747</td>
<td>4.4</td>
<td>62%</td>
<td>33%</td>
<td>6%</td>
</tr>
<tr>
<td>Nurse (Registered)</td>
<td>691,849</td>
<td>3.1</td>
<td>74%</td>
<td>18%</td>
<td>8%</td>
</tr>
<tr>
<td>Allied Health Professional</td>
<td>47,073</td>
<td>0.4</td>
<td>93%</td>
<td>3%</td>
<td>4%</td>
</tr>
</tbody>
</table>

#### Average daily CHPPD benchmark - Adult Mental Illness wards

**ADULT MENTAL ILLNESS**

485 wards
Average daily CHPPD = 7.75
Range = 0.16 to 55.48
Community Productivity – Community Nursing (indicative)

- An average 51% of a clinical worked day is spent conducting patient facing appointments (either face to face or telephone). This suggests that around 49% of time is spent on administration, travel, or other activities.

- The average number of contacts per clinical worked day is 7.7

- For the Cohort, the average length of a face to face contact for Community Nursing is 32 minutes.
Community productivity in adult mental health teams (indicative)

- An average 33% of a clinical worked day is spent conducting patient facing appointments (either face to face or telephone). This suggests **67% of time is spent on administration, travel, or other activities**.

- For **older adults** on average 31% of a clinical worked day is spent conducting patient facing appointments with only 2.9 contacts are conducted per day.

- For **CAHMS** the on average 36% of the clinical worked day is spent conducting patient facing activities and only 2.5 contacts are conducted per day.
**Estate**

- Variations in **costs per m² floor space**, for soft and hard FM, and utilisation of floor space by FTE per 100m²
- Majority of trusts in the cohort identified estates as an area they could make **savings as part of a wider transformation project**

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**Corporate Services**

- **Sectors benchmark higher** on corporate services using 2015/16 data
- Scope to consider benefits of **consolidation** at scale and across organisations
- **2016/17 data** to be collected in October

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**Procurement – PPIB!**
Next Steps
### Building the approach

<table>
<thead>
<tr>
<th>Department</th>
<th>Tasks</th>
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</table>
| CHPPD                              | • National data collection  
• Cost per care hour                                                      |
| Community Productivity             | • Validation and engagement  
• Develop strategy for extension                                           |
| Procurement                        | • PPIB collaborative  
• Develop understand of sector                                               |
| Estates                            | • Review ERIC data set  
• Develop weighted comparator                                                    |
| Corporate Services                 | • Renew costs based on new metrics  
• Explore impact of ‘difference’                                               |
| Medicines and Pharmacy             | • Analysing define data and developing metrics  
• Explore clinical model, skills mix and dispensing model              |
Model Mental Health Trusts and Community Services

Get your log in: https://model.nhs.uk

Priority 1

Priority 2

Expand

Extend
Outcomes and pathways

Getting it Right First Time

- A series of more than 30 medical work streams, each led by a prominent clinician chosen from the specialty they are reviewing.
- Each clinician heads a project to compile a data and insight driven report into their specialty
- Working to understand how to extend it to community service provision where relevant e.g. diabetes
- NHSI and GIRFT are developing the approach to the mental health pathway, working with Tim Kendall. Anticipate it is focused on reducing out of area placements

Wound care

- Very significant area of spend and rising – estimates suggest around £2.2bn in 2014 and rising to £2.4bn by 2019. Recognised that there is scope to prevent if the right clinical care is delivered
- Little consistent information is gathered – working with leads in NHSI and NHSE to develop and test a data collection process as a potential precursor to application of the GIRFT methodology
Enabling productivity

Commissioning Model
• Broad range and scope of commissioning specifications encountered, with many KPIs
• Working with NHS England and RightCare to scope the potential to develop a common menu of services, particular for community physical health, and smarter ‘model’ commissioning specifications across commissioners.

Demand and Capacity
• Majority of cohort trusts had limited capability or capacity to forecast demand forecasting in the medium term.
• Review working group to assess principles and processes to support effective demand and capacity planning and barriers to these.

Transforming the experience of working at the front line
• Investment in mobile IT largely positive, and good examples of use of current Patient Administration Systems.
• Broad agreement however that Patient Administration Systems were designed as a recording system, not a management system and nearly all trusts identified that there was scope to drive more benefit from technology through changes in business process and culture.
Questions