Developing Model Community Health Services

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Thursday, 24 January 2019
Lord Carter review (May 2018) found significant variation in the way mental health services are delivered

- Poor understanding and lack of data and measures of productivity
- Eliminating unwarranted variation could deliver £1bn of savings from the community and mental health sectors
- 16 recommendations engaging providers and ALBs in delivering improvements

1. Poor staff sickness & retention
   - Reducing high levels of staff sickness absence and turnover and increasing low engagement – all comparatively worse than the acute sector

2. Poor rostering and staff deployment
   - Tackling poor rostering and reducing unused hours to decrease the use of bank and agency. One trust identified over 6,000 unused hours

3. Deliver CHPPD to measure inpatient productivity
   - Delivering care hour per patient day metrics into community hospitals and mental health wards to increase utilisation of patient care time

4. Reducing variation in the community & increase use of technology
   - Reducing variation in community out of hospital productivity & improve the poor use of mobile technology. 25% of community nursing service remain on paper

5. GIRFT & reduce out of area placement
   - Do more in patient pathway and reduce inappropriate out of area mental health placements, restricted patients and better wound management in the community

6. Tackle non-pay variation
   - Need to strengthen contracting and tackle non pay variation

7. Extend the ‘model hospital’
   - Extending the approach of the model ‘hospital’ to cover mental health and community trusts so data & comparative performance is transparent to boards & managers
Sector Development is on track with delivering the key objectives set by the Carter review

**Building an effective implementation programme**

- Extending inpatient metrics to community hospitals (CHPPD and associated costs)
- Designing Model Mental Health Service (MMHS) and Model Community Health Services (MCHS)
- Developing guidance for the Service Delivery Model for community services
- Extending GIRFT
Launched Model Community Health Services and Model Mental Health Services

Stand alone Community Health Mental Health Trusts can now see data on:

- **Corporate services** (Legal/HR/Payroll/IM&T/Governance and Risk/Finance/Procurement)
- **Estates and Facilities** (hard and soft FM, adjusted for PFI and unadjusted)
- A range of ‘People’ compartments including nursing and midwifery and AHPs.

First clinical service line compartments for Mental Health services delivered in community launched in November 2018 with four more planned for Jan
CHPPD metrics are now live on the Model Hospital for community and mental health inpatient wards

Next steps:
• National CHPPD Publication in January 2019
• CHPPD Self-Assessment tool for trusts and regional teams publication in February 2019
• AHP staff data analysis in February 2019
Guidance on e-rostering and e-job planning was launched in November 2018

Levels of attainment and meaningful use standards developed

Analysis underway on data submitted by trusts based on levels of attainment for August 2018.

38% of community respondents not meeting the minimum levels of attainment.

Rostering and job-planning practice must be prioritised if we are to make the most of workforce and meet demand

Next steps
• Medical workforce data for community and mental health inpatient wards will be uploaded to the Model Mental Health service / Model Community Health service in April 2019
Development of metrics for services delivered in the community is ahead of schedule

Progress to date:

- 6 compartments for mental health service delivered in community with activity and caseload metrics
- Piloting staff data collection with 53 mental health trusts for the development of productivity metrics

Overview of community mental health services, including caseload and waiting list management, and frequency of patient contacts.
Early analysis shows significant variation in productivity of services delivered in community and significant data quality issues.

For community mental health, the average number of contacts per patient seen in month ranges from 0.4 to 14.3 across trusts.

There is significant variation in the percentage of patients on caseloads without a care contact.

For crisis home treatment, the median number of days between first and second contact ranges from 1.5 to 29 across trusts.
Capturing impact and outcomes in community services is vital for demonstrating the value they deliver.
Value in health care must be measured by the outcomes achieved, not the volume of services delivered, or the process of care used (Porter, 2010)

Porter’s Value Equation

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\text{VALUE} = \frac{\text{OUTCOMES}}{\text{RESOURCES}}
\]

**OUTCOMES**
- Clinical Effectiveness
  - E.g. population health, survival rate, extent of functional recovery
- Patient Experience
  - E.g. comfort, treatment by staff, waiting time, ease of access
- Safety
  - E.g. diagnostic error, post-operative complications, infections

**RESOURCES**
- Revenue Costs
  - E.g. income, salaries, system maintenance, facilities
- Capital Costs
  - E.g. investment in infrastructure or equipment
- Non Financial
  - E.g. staffing resources, capacity, systems and infrastructure
The review found variation in the operating models for services delivered in the community.

Four areas of a service delivery model were found to apply specifically to community services.

The report recommended that providers modernise their delivery models and that NHS Improvement develops guidance to support this.

We have been working with a reference group to define the following for each of the above areas:

- Long term aspiration
- Enablers
- Performance measures
- Case studies of good practice
Inadequate access processes and caseload management lead to inefficient use of resources and poor patient outcomes

**Process for accessing services**

Providers told us:
- The system should move towards having a Single Point of Access (SPA) for all health and care services in a locality.
- In preparation for this, providers should ensure their services are accessed through a SPA.

**Caseload management**

Providers told us:
- Good caseloads management needs robust processes as well as clinical decision making.
- Most providers did not have clear policies and procedures explaining their approach to caseload management.
- Caseloads reporting and monitoring needs to improve.
- Principles of good caseloads management apply for services with a population management approach as well as for traditional service models.
Mobile working is essential for improving workforce productivity and changing the way services are delivered

Providers told us:
• Not to underestimate required engagement with staff or time taken to yield benefits
• Suppliers should be involved in change management processes
• Providers should be creative in overcoming connectivity issues to deliver the best solution for staff

Providers told us:
• There is significant opportunity in using video to deliver clinical contacts, particularly in care and nursing homes
• We should do more to explore opportunities offered by remote monitoring and wearable devices
• We should not assume that patients prefer traditional delivery methods to those using technology
GIRFT programme is reviewing the role of community health services in all workstreams

Piloting GIRFT approach in wound care services delivered in the community to reduce unwarranted variation in clinical quality, productivity and efficiency

Considering options for extending prioritising GIRFT workstreams to extend into community:

- Aligning to Right Care priority areas (MSK, Frailty and Elective Care)
- Using Urgent Care Sensitive Conditions (COPD, non-specific chest pain, falls, non-specific abdominal pain, deep vein thrombosis, cellulitis, blocked tubes/catheters/feeding tubes, hypoglycaemia, UTIs, angina)
- Identifying areas with good progress towards utilisation of community resources for piloting a framework of assessment – e.g. Diabetes, Respiratory.
Developing value-based performance approach to community services

Building on the recommendations of the Carter review and aligning with the NHS Long Term Plan

- Release activity metrics for community health service lines in Spring 2019
- Launch productivity metrics for mental health services in Spring 2019
- Extend scope of staff data collection and launch productivity metrics for CHS in Summer 2019
- Publish guidelines on Service Delivery Model in Spring 2019
- Improve data quality (CSDS, MHSDS, staff data)
- Begin to align productivity to quality and outcome measures
- Understand success in productive delivery and spread good practice