Leicestershire Partnership NHS
NHS Trust

HEALTH AND WELLBEING BOARD: 5 DECEMBER 2013

REPORT OF LEICESTERSHIRE PARTNERSHIP TRUST

ACUTE MENTAL HEALTH BED OCCUPANCY

Purpose of report

1. The purpose of this report is to:

   - provide information and analysis regarding the current high levels of bed occupancy in the Leicestershire Partnership Trust's (LPT) acute adult mental health wards (148 beds in total);
   - describe the action being taken by LPT with partner organisations to address the pressure on beds and reduce the need for out of area placements.

Background

2. During 2012/13 there has been an overall increase in the bed occupancy rate in the acute wards which is currently in the region of 99%. In 2011/12 the average monthly bed occupancy rates were approximately 96% with odd months when they were 100%.

3. The Trust's Adult Mental Health (AMH) division has taken a number of actions over the last 18 months to improve both the admission and discharge processes to reduce bed occupancy and create capacity in the system to manage the demand for beds – these include:

   - Implementing an Acute Care Pathway (what should happen when from admission to discharge)
   - Redesign of the crisis resolution and home treatment (CRHT) service and a single point of access (currently being reviewed by the CCGs and Trust)
   - Implementation of a robust pre-admission process
   - Recruitment of a discharge facilitator/bed manager
   - Establishing a bed management/discharge team
   - Establishing bi-weekly discharge planning meetings
   - Establishing regular meetings with senior local authority colleagues to review delayed transfers of care

4. Through this work considerable improvements have been made in both the admission and discharge processes. Robust gate-keeping via CRHT is in place and where appropriate, home treatment as an alternative to admission is offered plus the CRHT facilitates early supported discharge (EDP) direct from the acute inpatients wards. The discharge facilitator and bed management function is now very well established in the service and bi-weekly discharge planning meetings have been implemented and are having a positive impact with progressing delayed transfers of care (DTOC).

5. Significant progress has been made to date and there is a clear understanding of what the pressures are in the system. Despite the implementation of the acute care pathway and the concentrated efforts to improve the admission and discharge processes, the demand for beds remains high and whilst there are still areas in the admission and discharge process where further improvements may be possible, longer term solutions need to be considered in order to cope with the growth in the population and the potential increase in demand for acute mental health beds.

National context

6. It was reported recently in the Health Service Journal (HSJ, 11 Oct 2013) that nationally there has been a 31% reduction in the number of mental health beds; in 2003-04 there were 32,252 whereas in 2013 this has reduced to 22,109; added to this there has been a 6% increase in the number of detentions under the Mental Health Act. In 2003-04 there were 45,691 detentions compared to 48,631 in 2011-12, this has led to an increase in Trusts having to access beds outside their catchment area. In essence this has resulted in some patients having to travel 200 miles to access an acute bed when experiencing a crisis. Much of the national context has been attributed to the removal of acute beds and in Leicester, Leicestershire and Rutland (LLR) there has been a reduction of seven acute beds in 2011-2013 solely attributable to the development of new slightly smaller wards in keeping with best practice.

7. Other contributory factors reported in the HSJ are (national) limited investment into community mental health services; the reduction in day care and other support for service users due to financial pressure in health and social care budgets. In LLR, the CRHT is the only statutory service available to support patients to remain in the community as an alternative to an acute admission and there are no 'intermediate care' facilities (as there are for people with physical health needs) between hospital and home, such as a crisis house.

Local context (demographics)

8. The current LLR population is just under one million and has increased by approximately. 7.5% in the last decade with predicted growth over the next decade of 11 -15%.

9. The population of Leicester City is 306,600 and is noted to have high levels of deprivation. The City has significantly worse rates of unemployment in working age adults and admissions for alcohol attributed conditions in Leicester are significantly worse than the national average. One in six people in the City have a long term life limiting illness and Leicester City has a lower than average uptake for physical activities, all of which have an impact on mental wellbeing.

10. Leicester City has a significantly higher proportion of the population registered by GPs as having a mental illness than in England and the East Midlands with an estimated 3,400 people having a serious and enduring mental illness and approximately 30,000 suffering from anxiety or depression. Nationally, Leicester City has higher rates of emergency admissions due to self harm.

11. In Leicestershire the number of people with a common mental health problem is in the region of 65,151 which is proportionate to the City in terms of population,

however, the prevalence of severe and enduring mental illness across Leicestershire and Rutland is lower in comparison to the City with 4,862 people diagnosed with borderline personality, antisocial personality disorder or a psychotic disorder. Given that the population in Leicestershire is almost double that of the City the difference is striking.

12. The predicted growth in population over the next decade, the prevalence of mental ill health across LLR and the shortcomings of community based provision are important considerations for future health and social care planning.

NHS Mental Health Benchmarking 2012 - Adult Acute beds

13. Forty three Trusts contributed to the 2012 NHS benchmarking exercise which allows reliable comparison of the Trust's provision and bed occupancy with many other NHS providers of mental health.

14. In terms of adult acute beds capacity, LPT is marginally higher than the average with 148 against an average of 139. However, the Trust's PICU (psychiatric intensive care) bed numbers are lower - 10 against an average of 15. The number of adult acute beds per 100,000 population varies considerably across the 43 NHS providers ranging from 15 to 53 beds per 100,000 population with a median position of 23 beds per 100,000 population. LPT has 21 beds per 100,000 population which is just short of the national average.

15. Analysis of the bed occupancy data for adult acute beds reveals a median occupancy rate of 91% across 43 providers. Interestingly the range is quite low with the lower quartile at 85% and the upper quartile at 95%. Out of 43 providers, five reported occupancy lower than 80% and three reported occupancy over 100%, LPT's occupancy rate was reported as 96%.

16. The number of adult acute admissions has been calculated per 100,000 population and there was a huge variation ranging from 150 per 100,000 population up to 550 per 100,000 population. Key factors in the variation include local needs; number of beds; length of stay and availability of beds for new admissions. The median position was 234 admissions per 100,000 population and LPT was a little higher with 260 per 100,000 population but still below the upper quartile.

17. The number of occupied bed days is calculated per 100,000 population and again there is great variation between providers ranging from 5,000 to 16,000 per 100,000 population. This is influenced by the number of beds provided and the average length of stay of patients and should also be cross referenced to the range of community services provision. The median position is 8,125 occupied bed days per 100,000 population and LPT's position is almost the same.

18. Length of stay and delayed transfers are two of the important performance measures for mental health providers. The mean length of stay averaged 32 days across the 43 providers. Length of stay is influenced by a number of variables including the acuity of the caseload, extent of delayed transfers of care and ability to hand patients over to community based services. LPT's mean length of stay was towards the upper quartile at 38 days. Delayed transfers of care (DTOCs) are presented as a percentage of the total bed days lost due to delays. DTOCs are those patients who are ready for discharge but for various reasons their discharge is delayed e.g. waiting

for an alternative placement, packages of care etc. The median position nationally is 3.5% as is the position for LPT.

19. It is reassuring to note that according to the NHS national benchmarking data LPT is certainly not an outlier in terms of numbers of beds; numbers of beds per 100,000 population nor any of the following key performance measures: occupied bed days, bed occupancy rates and number of admissions and delayed transfers. However, the mean length of stay is an area where LPT was towards the upper quartile and according to the LPT data presented in this report has increased in 2012/13.

LPT summary data for the period April 2013 – October 2013

20. The data presented in the tables below is a summary of key performance measures for the acute wards (148 beds).

Table 1 Bed occupancy data April – October 2013

Month	Bed occupancy	Admissions	Discharges	Average LOS	DTOC (total in period)
April	96.4%	90	97	36.1	12
May	99.0%	95	100	55.7	20
June	99.2%	92	90	40.7	23
July	94.6%	118	134	46.9	21
August	95.3%	84	83	53.4	16
September	93.4%	95	94	41.9	15
October	96.4%	110	109	44.8	21

21. The data presented in table 1 shows that bed occupancy has been largely in the mid-90s or above and that the number of monthly discharges and admissions are similar except in July. Most notable is the average length of stay (LOS) which although fluctuating, has seen an overall steady increase. In April it was 36.1 days and in October it was 44.8, reaching highs of 55.7 and 53.4 days in the intervening months which correlates with the overall increase in bed occupancy rates and pressure on bed capacity.

22. Whilst the DTOC figures do not necessarily show an improvement it must be noted that prior to the introduction of the discharge planning meetings there was an under reporting of DTOC across adult mental health wards including the rehabilitation wards, hence the apparent increase after April.

Table 2 Out of area placements April – October 2013

Month	Patients admitted out of area in month	Patients using an out of area bed in month	Patients out of area as at end of month	Number of out of area bed days in month
April	6	9	5	87
May	11	16	11	214
June	15	25	8	300
July	5	15	3	242

Aug	21	24	19	256
Sept	14	33	19	665
Oct	26	46	27	752

23. Table 2 shows the number of out of area placements which have increased significantly since August 2013. Whilst initial interpretation shows a correlation with the steady increase in the average LOS more work is required to understand the impact of the very complex delayed transfers of care and their causes such as lack of suitable accommodation particularly for homeless people. Understanding and addressing the small factors which contribute to patient flows will require analysis of individual patient's progress through the system.

24. LPT has just begun analyzing admission and discharge trends over a three year period which shows a marked reduction in the number of admissions and discharges overall, particularly after January 2013. What is beginning to emerge is the impact that the new bed management process and robust admission process via CRHT has had since it was introduced in January 2013. It is important to note that prior to this patients would be admitted to the unit whether there was a bed available or not and the gate keeping function of CRHT was not as robust as it is now. As part of this further analysis of the last three years data the Trust will look at all patients whose length of stay was above average and identify any common factors which unnecessarily prolonged their stay in hospital.

Conclusions

25. The report has described the importance of the operating context of the Trust's adult mental health services and in particular the variables which influence bed occupancy and length of stay, namely:

- Acuity of the caseload;
- Extent of delayed transfers of care;
- Lack of access to step up step down or crisis facilities;
- Ability to hand patients over to community based services.

26. The Trust has taken practical action operationally to address the current position through:

- Implementing the Acute Care Pathway – redesign of CRHT and establishing a SPA;
- Implementing a robust pre-admission process;
- Recruiting a discharge facilitator/bed management post;
- Establishing a bed management/discharge team;
- Establishing bi-weekly discharge planning meetings;
- Establishing regular meetings with senior LA colleagues to review DTOC.

27. It is important for the Board to note that work on bed occupancy is part of implementing the AMH Quality Improvement Program (QIP). The QIP focuses on the acute care pathway and reviewing the admission, inpatient and discharge processes alongside a review of the current service model provided by CRHT, which will continue to make improvements across the pathway and make a positive impact on reducing the average LOS.

28. The local commissioning intentions next year are aimed at improving access to community services. The Trust's community re-design project is very much part of those intentions is committed to working with the CCGs to redesign services to improve the overall service framework for our population. LPT facilitated a crisis house event on the 28th June 2013, in partnership with the CCGs and City and County Councils, which clearly showed support for one from service users and further work is currently underway led by the CCGs and councils to explore this as an option and consider appropriate models that would work across LLR. Impacting on reducing LOS on the acute wards via internal changes to the LPT's current service provision alone is unlikely to be realized in the short or medium term without reviewing the overall health and social care service offering for people with acute mental health problems and prioritizing resources.

Recommendations

29. That the board

(a) considers and comments on the report;

(b) endorses LPT's approach to improving patient flows and managing bed occupancy to reduce out of area placements.

Background papers

Leicestershire Partnership Trust Adult Mental Health Quality Improvement Programme.

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