

Getting It Right First Time: Mental Health Rehabilitation

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Getting It Right First Time

Clinically-led programme, reducing variation and improving outcomes



GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement

Introducing GIRFT

- Review of **40+ clinical specialties** leading to national reports for each.
- Led by **frontline clinicians** who are expert in the areas they are reviewing.
- **Peer to peer engagement** helping clinicians to identify changes that will improve care and deliver efficiencies, and to design plans to implement those changes.
- Support across all trusts and STPs to drive **locally designed improvements** and to share best practice across the country.
- Regional delivery hubs – supporting implementation of action plans
- Agreed **efficiency savings**: up to £1.4bn by 2020-21, starting with between £240m and £420m in 2017-18.

Tackling unwarranted variation to improve quality of patient care while also identifying significant savings.



From pilot to national programme

Process:

- Engagement - Set data requirements then collect data.
- Trust / CCG / LA – level analysis.
- Visits to every Trust / CCG / LA – develop an action plan.
- Regional implementation support. **National report, recommendations.**
- **Share good practice.**
- Using GIRFT to drive a culture of continuous improvement in trusts.
- Webinars
- Regional meetings / sharing of best practice and Quality Improvement work

GIRFT local support



GIRFT Regional Hubs support trusts in delivering the Clinical Leads' recommendations by:

- Helping them to assess and overcome the local and national barriers to delivery.
- Working closely with NHSI regions to ensure prioritisation of GIRFT delivery takes account of the wider context within each trust and is joined up with local and regional improvement initiatives.
- Joining up with NHSE/RightCare to ensure integrated support for STP level improvements.
- Producing **good practice manuals** of case studies and best practice guidance that trusts can use to implement change locally.
- Supporting mentoring networks across trusts.

Each hub will have two **clinical ambassadors**: regionally recognised leaders of improvement programmes

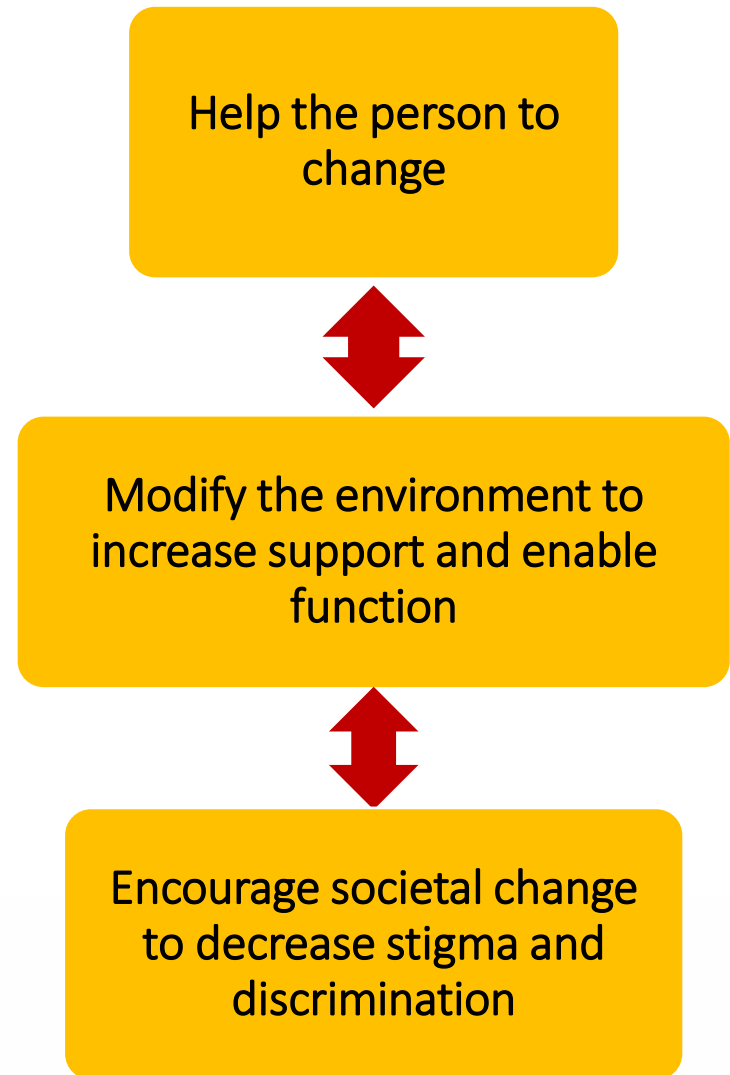
CQC report: The state of care in mental health services 2014 to 2017

- 3,500 people in 'locked rehab' settings. Cost approx £500million / year across England
- Most are OATS and around 2/3 are in the private sector
- OATs are not good value
- Many MDTs are not sufficiently well trained in rehabilitation, to provide high quality, intensive rehabilitation

What is Psychiatric Rehabilitation & Recovery?

“A whole system approach to recovery from mental ill health which maximises an individual’s quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support.”

(Killaspy et al, 2005)



IMPACT OF INSUFFICIENT REHABILITATION SERVICES ON OTHER PARTS OF THE MENTAL HEALTH SYSTEM



Acute
Psychiatric
Inpatient
Delays(16% -
Crisp Review)



Out of Area
Placements –
acute and
Rehab;
**Winterbourne
Whorlton Hall**

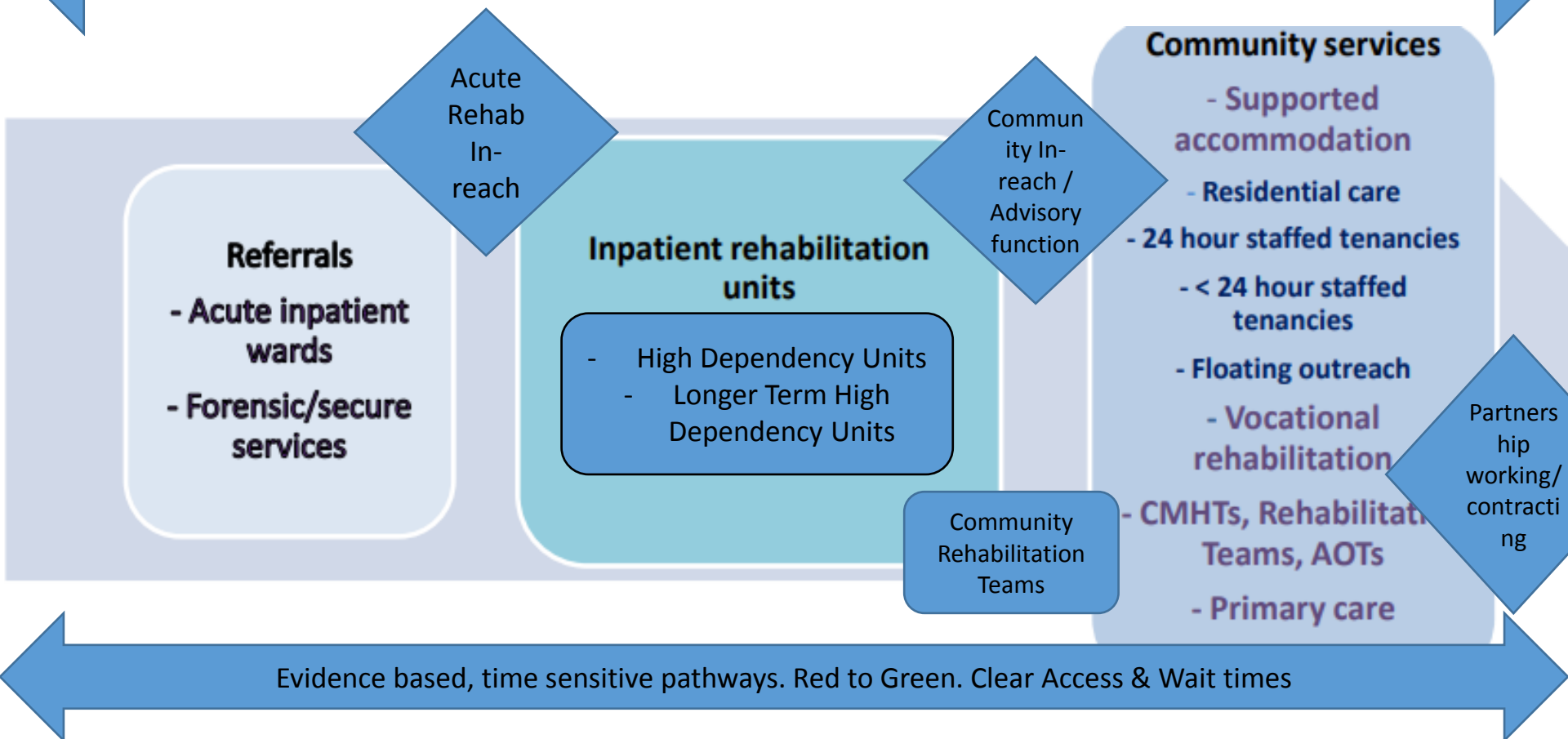
Revolving door
readmissions &
Placement
breakdowns



Neglect in the
community

A whole system approach to mental health rehabilitation services

Flexible, personalised care packages – health & social care to optimise rehab, recovery and outcomes. Pre-agreed ability to dial up and down

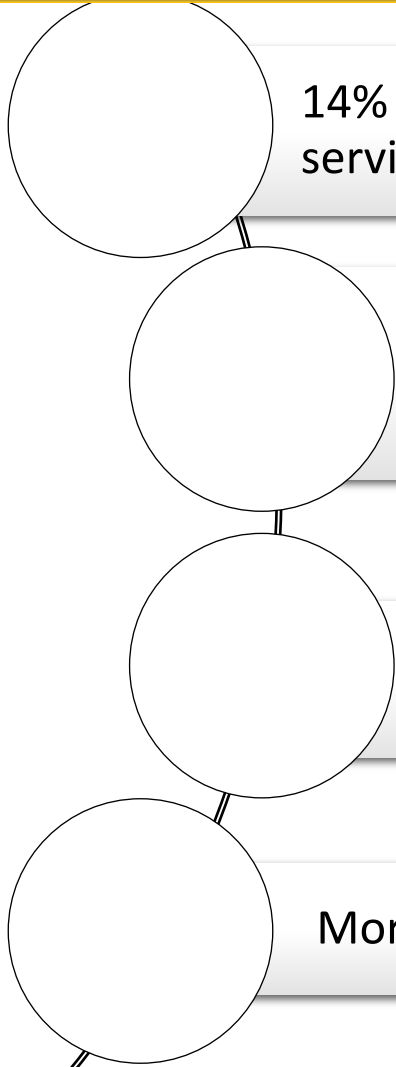


Rehabilitation Psychiatry

- 85% Psychosis – longer term conditions
- Treatment resistance
- Negative symptoms
- Comorbidities, psychiatric and physical health
- Functional impairments – Activities of Daily Living
- Challenging behaviour
- Difficult to engage
- Risk
- (Holloway, 2005)
- ~14% of EIP require rehabilitation; earlier transfer better
- Approx. 10-15% of those in secondary care, account for 25-40% of the annual UK mental health and social care budget (MH Strategies 2010 & Killaspy 2010)

The principles of rehab are relevant to all Mental Health services

Evidence for rehabilitation services

Four white circles of varying sizes are arranged vertically on the left side of the slide, connected by thin black lines. The circles are positioned to the left of the four text boxes.

14% of people newly diagnosed with psychosis will require rehabilitation services (Craig et al, 2004)

Long term view/evidence: 65% of this group achieve successful, sustained community living over 5 years and 8% achieve independent living (Trieman and Leff, 2002; Killaspy and Zis, 2012)

Support from rehabilitation services: 8x ↑achieving /sustaining community living compared to generic CMHTs (Lavelle et al, 2011).

More evaluation data from recent publications – Bunyan, Killaspy, 2016

IN-PATIENT REHABILITATION: CLINICAL OUTCOMES AND COST IMPLICATIONS, BUNYAN ET AL, 2016

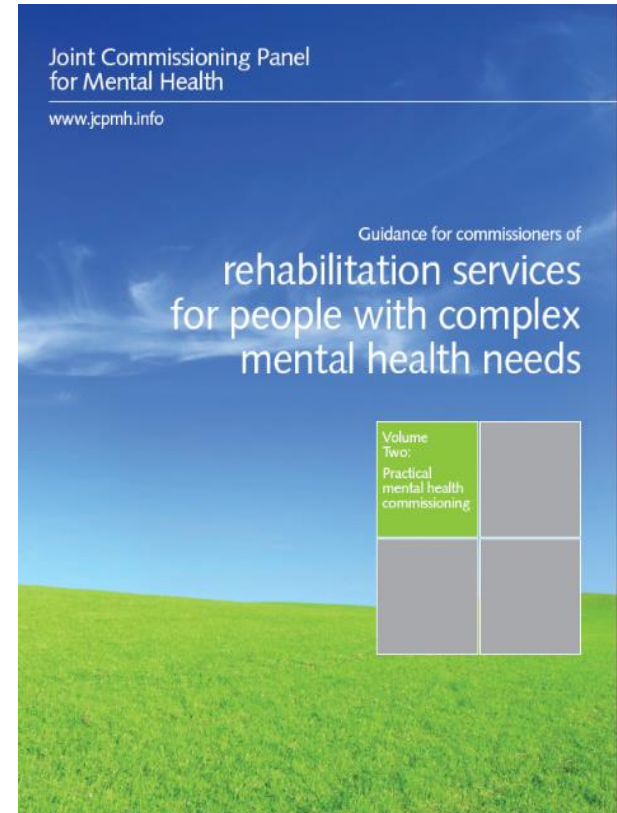
Table 1 Admission costs per year pre- and post-rehabilitation

	Pre-rehabilitation	Post-rehabilitation	Statistics
Individual cost, mean (s.e.)	£66 000 (£10 000)	£18 000 (£9000)	$t_{(21)} = 3.200, P = 0.004$
Total cost ($n = 22$)	£1324 000	£386 000	

A National Strategy

- **National Commissioning Guidance**
- **Rehab services continues to wax and wane around the country**
- **NICE Guidance now underway**

<https://www.rcpsych.ac.uk/members/your-faculties/rehabilitation-and-social-psychiatry/news-and-resources>

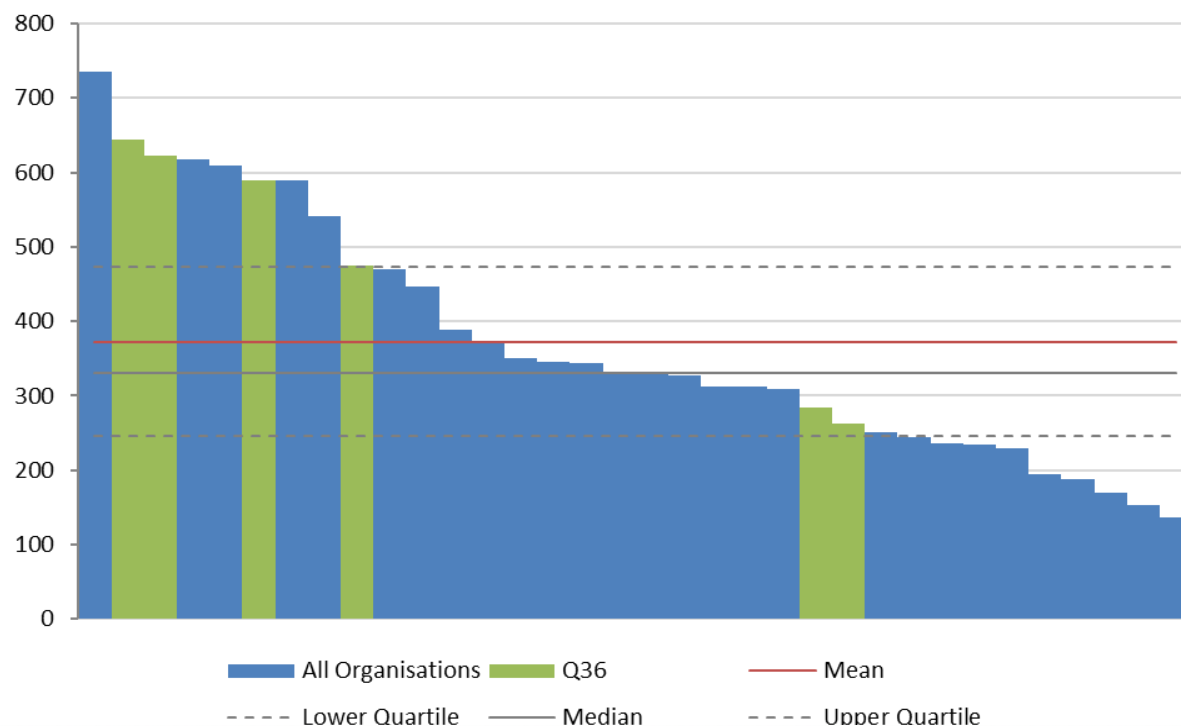


High Dependency Rehabilitation – Length of stay

NHS Benchmarking Network

- Average 372 days for patients discharge in year
- London peer group highlighted

High Dependency Rehabilitation - Mean length of stay for patients discharged in year

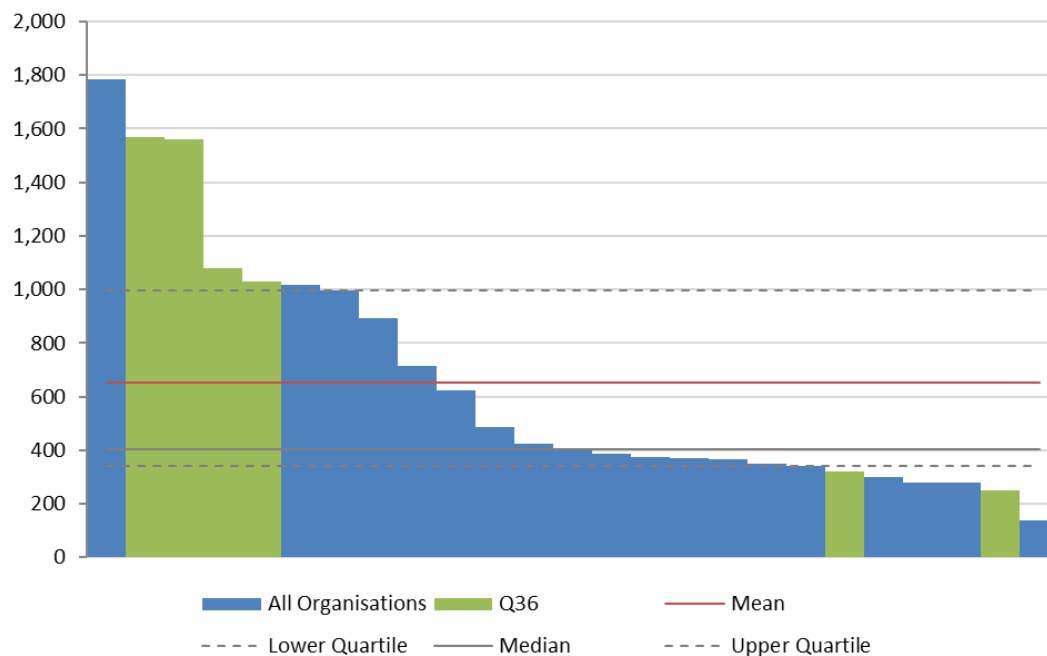


Long Term Complex Care – Length of stay

NHS Benchmarking Network

- Average 653 days for patients discharge in year
- London peer group highlighted

Longer Term Complex / Continuing Care - Mean length of stay for patients discharged in year



RESEARCH ARTICLE

Open Access



Clinical outcomes and costs for people with complex psychosis; a naturalistic prospective cohort study of mental health rehabilitation service users in England

Helen Killaspy^{1,2*}, Louise Marston^{3,4}, Nicholas Green¹, Isobel Harrison¹, Melanie Lean¹, Frank Holloway⁵, Tom Craig^{5,6}, Gerard Leavey⁷, Maurice Arbuthnott⁸, Leonardo Koeser⁹, Paul McCrone⁹, Rumana Z. Omar^{4,10} and Michael King^{1,2,4}

Contact with mental health services

- Time since first contact (years)
median: 12 (6, 20)
- Previous admissions median: 4 (2, 7)
- Previous involuntary admissions
median: 2 (0, 4)
- Length of current admission (months)
median: 18 (9, 38)
- Length of current admission in rehabilitation unit (months)
median: 7 (3, 15)

MORTALITY GAP

In south
east London

16 years
for women

18 years
for men

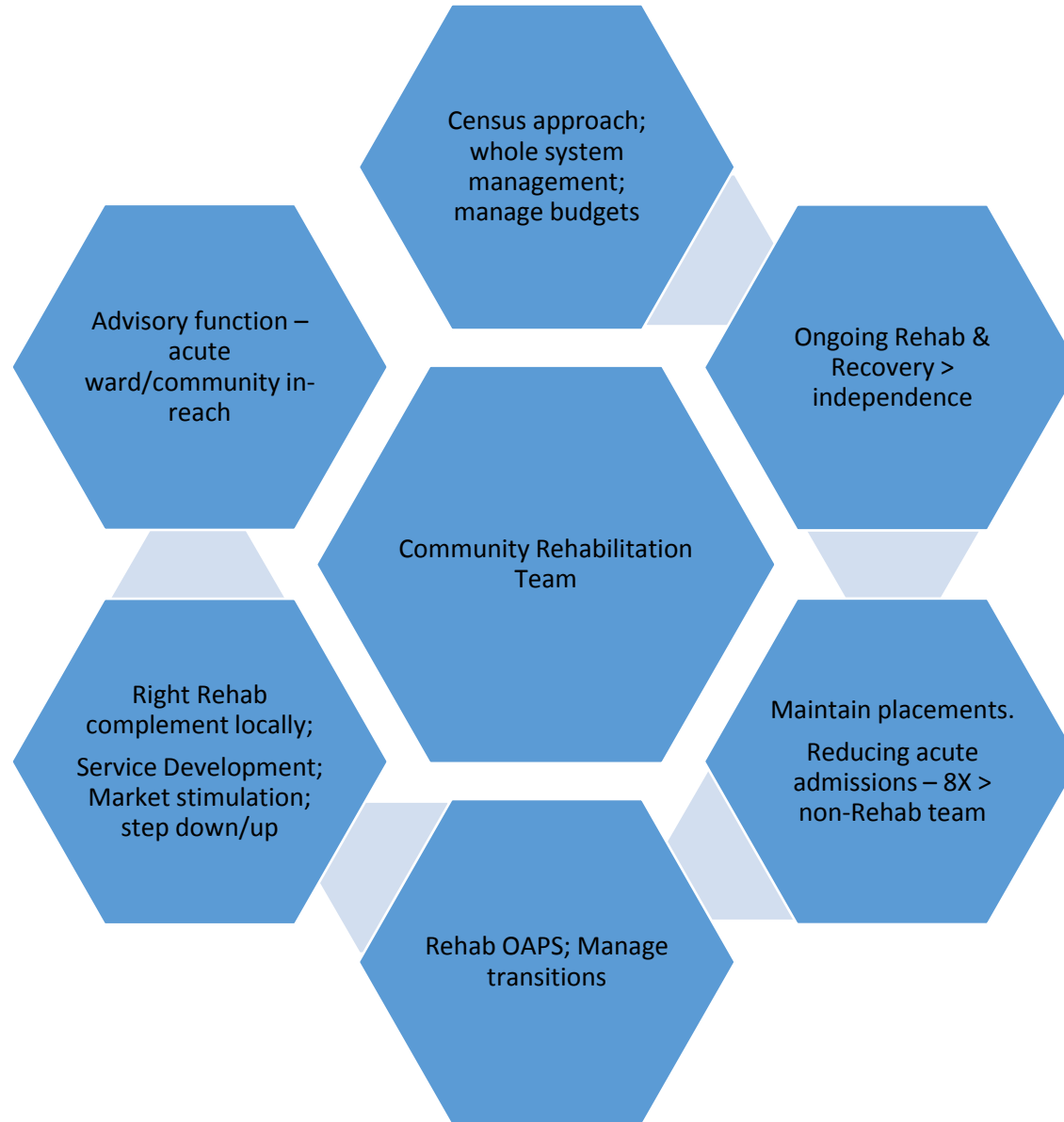
Cause: Most deaths from
physical health
conditions CVD, Stroke

Partly due to socio-
demographic factors –
health inequalities

It is 'lethal discrimination'
at worst, at best, failure
to act on evidence

©

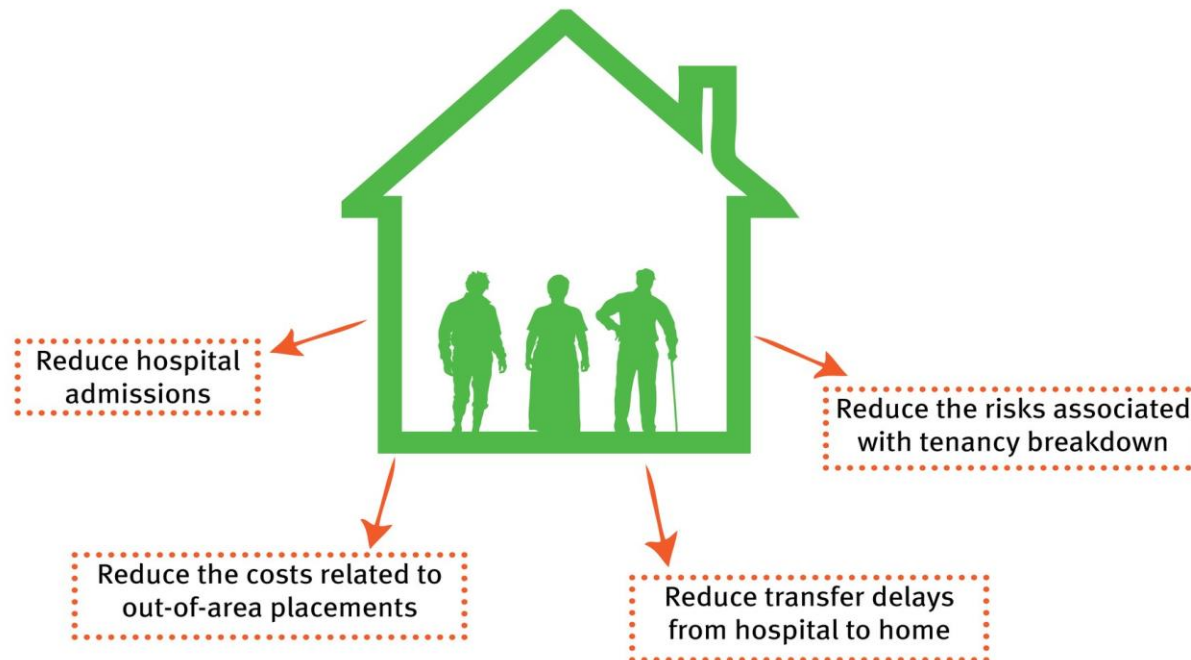
Community Rehabilitation team functions



Recognising housing as a mental health intervention



The provision of supported housing can...



© Centre for Mental Health, 2016. From *More than shelter* (2016) available at www.centreformentalhealth.org.uk/more-than-shelter



The Cheshire & Wirral Partnership Rehabilitation Pathway

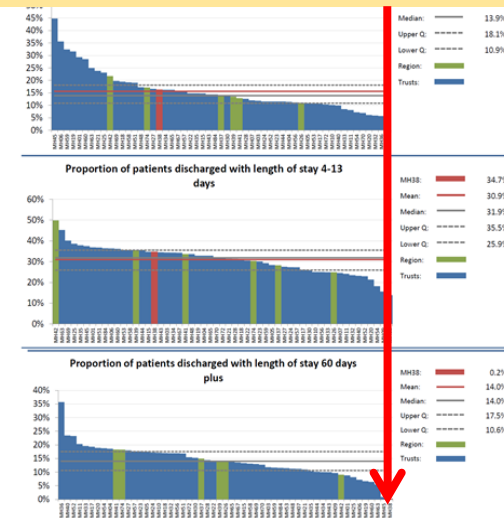


Outcome

CWP has the lowest number of patients with length of stay of 60 days or over in acute care

- **High Dependency Inpatient rehabilitation** (27 beds)- (centrally located)
- **Complex Recovery Assessment and Consultation (CRAC) Service**- provides specialist clinical second opinion via in-reach to acute care & Care co-ordination of all out of area inpatient placements including all secure.
- **Less intensive inpatient rehabilitation** provided by another provider- partnership working
- **Central gatekeeping & placement decision process.**
- **Close working relationships** with Commissioners, Local Authority and housing/support workers

Despite having a **very low acute bed base** within lowest quartile in NHSBN -**Zero** people out of area for acute care from **January 2016-November 2018** then only out of area because they presented out of area, were not sent by CWP



CWP is supporting the repatriation of people from out of area and back into the community via the CRAC Team & partnership working

CWP are now working with all stakeholders to develop community rehabilitation services across CWP to reduce the reliance on inpatient services, and support people to be in the least restrictive setting for their needs closest to home

Everyone needing rehabilitation/complex care is in sight and in mind and their strengths, needs and aspirations are well known to inform developments.

- Understanding the need of the local population for rehabilitation services:
 - based on data
 - local context
 - using good practice models
 - evidence base
 - co-produced – service users, carers, other stakeholders across the system
- Rehab dashboard
- Understanding workforce need and competencies
- How can GIRFT rehabilitation support you?

Thank you

Thoughts

Questions

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