Mental Health Today
Learning Curve

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Breaking the constraints

How a mental health trust improved quality of care, reduced lengths of inpatient stay and created essential bed capacity using a patient-led management theory

The initiative sought to find new ways to alleviate bed pressures within budgets without increasing capacity.

In early 2012, Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT) had a problem, which was affecting the whole organisation. Service users were being admitted for an average of 70 days, but at any one time about 25 beds were blocked by delayed discharges, resulting in a poor service user experience and £1.5 million a year being spent on private sector beds.

To combat this, in February 2012 BEH-MHT, which provides assessment and inpatient care for service users across three hospital sites in North London and community services for people living in the borough of Enfield, embarked on an initiative with management consultancy and specialists in Theory of Constraints methodology QFI Consulting to understand why service users were staying on wards for longer than expected. The initiative also sought to find new ways to alleviate bed pressures within budgets without increasing capacity.

“Before we began working with QFI, blocked beds were seen as our own entrenched problem, by us and by colleagues outside the trust,” says Oliver Treacy, services director of the trust’s Crisis and Emergency Service Line.

Performance measures

This was just one of the issues that the trust was experiencing. “Inner-city emergency mental health is undoubtedly one of the toughest environments in which to work,” explains Helen Muir, project manager at QFI.
“When we began talking to staff, we uncovered a series of deep-rooted issues

that they identified as reasons why it was taking a long time to discharge a high proportion of service users. They felt there were often no available services for service users to be discharged to, and that their social problems were insurmountable; that they were the ingrained problems of the inner-city and too hard to solve."

But there were other factors at play, as Muir explains: "Staff and managers assumed that delays were mainly due to external factors – typically a lack of suitable and safe housing – but we were able to show them how their own behaviours and processes could be delaying care and treatment.

"For example, we found there wasn't enough knowledge, understanding or meaningful communication between hospitals, staff, community-based care coordinators and accommodation providers. This meant that the hospital was missing the opportunity to put in place suitable accommodation in good time for a patient's discharge.

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"We found service users who were clinically ready to be discharged but were staying in hospital or being transferred to private accommodation, at significant cost to the trust, because they had no other housing to go to."

Bed management

At the centre of the issue of delayed discharge was the trust's policy to admit service users to the next available bed in any of its hospitals, rather than prioritising their admission to a ward in their home borough. This made it difficult for family, friends, and – crucially – care coordinators to visit and follow up treatment plans.

"This wouldn't have been such an issue if care coordinators could travel freely to visit service users, but their workloads and logistics meant this wasn't practical and their role, which is strategically very important, was being compromised," explains Muir.

"Without the close involvement of care coordinators, whose role is to deal with social care needs and liaise with external agencies, preparations for ongoing care and discharge were being severely delayed."

The situation was compounded by the complexity of social and community issues in many mental health cases, which often means local housing and home office agencies first have to define whether the patient has a genuine need or entitlement for social housing before suitable arrangements can be made. Without good communication, transparency, open mediation and problem solving between clinicians and agencies, service users were staying in hospital beds far longer than necessary.

"The complexity of the situation had become inextricable, and shared frustrations had resulted in a stand-off between agencies," says Muir. "Also, having no formal, workable policy or system to manage beds centrally was a big stumbling block for the trust and its delivery of services."

The Theory of Constraints approach

Having identified the root causes of delay that were damaging the performance of the whole organisational system, QFI worked with the trust to design a series of new ways of thinking based on Theory of Constraints principles and introduce a new approach to working called QFI Discharge Jonah.

"This initiative untangled and systematised the reasons beds were being blocked,"

Oliver Treacy
Services Director

Theory of Constraints views any manageable system as being limited in achieving more of its goals by a small number of constraints. The constraints are then identified and attended to.

"This initiative untangled and systematised the reasons beds were being blocked," says Treacy.

Now, working with QFI, clinicians calculate each service user's planned discharge date, assuming all the clinical services would be available when they were needed. Key clinical and social care tasks are highlighted for action during the service user's journey, with task times and task managers. Any potential social, accommodation and welfare issues are flagged for discussion with care coordinators and housing agencies. Within 24 hours of admission each patient is given a planned date of discharge and these are recorded in an active database that all health and social care staff have access to.

"We encourage staff to continually think about the goal of this episode of care and how long the service user really needs to be in their care," explains Muir. "We ask them to put a realistic end-point on patient care that everyone can work towards. In this way, clinicians quickly become more task-orientated and can see how their actions are helping service users to get better and progress out of acute care."

Other changes to working practices have been made too. For example, where there had previously been many points of entry to inpatient care, the trust agreed that the Home Treatment Team should coordinate all admissions. A capacity and flow manager and a centralised bed management team were recruited from existing staff to coordinate all available capacity across the trust, including home treatment places, inpatient and recovery house capacity, and transfer management.

Following assessment, service users were allocated a bed in their own borough wherever possible. This meant the involvement of care coordinators could be guaranteed and a full review of the patient's needs made within 72 hours of their admission.

There is now a focus on confronting and addressing issues as quickly as possible so that they don't delay a patient from being discharged at the right time. This includes flagging and addressing social housing and community care needs early so that suitable provisions are in place by the time the service user is ready for discharge. Regular meetings with council housing officers ensure a policy of joint responsibility and working is maintained.

The effects of this approach quickly became obvious: within five weeks, the length of stay dropped from 50 to 29 days, and that figure has been sustained in 2013.

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Cultural shift

"We have adopted and accepted the QFI Jonah initiative as our new culture," says Jackie Liveras, assistant director of BEH-MHT's Crisis and Emergency service, who led the project on behalf of the trust.

"It's a common sense approach that is making us think, act and work differently. It's all about starting to think early in a patient's stay about potential issues that could cause delays later on. This usually means identifying social care issues and starting to address them with the right agencies straight away.

"In mental health, joint, multi-disciplinary working is essential to successful treatment and flow because people with mental health problems usually have other social and lifestyle issues. Above all, this project has shown how crucial it is for us to communicate, and to communicate in a clear, constructive, regular way with other professionals and providers who share our goals."

Treacy adds: "Having discovered that one of the biggest underlying causes of blocked beds was partnership issues, we were able to engage more closely with the local authority and create an accountability framework that spreads responsibility for the problem and gives us the opportunity to resolve issues fairly between us.

"The new approach allows us to chase and remedy bad practice. It has created an awareness of how costly beds are to operate, which in turn has motivated staff to engage with the new system."

Empowering staff and service users

For example, ward managers now lead daily meetings, which are more clinical, structured and shorter than before. Top delay meetings take place once a week and focus on the 20 most delayed cases. These involve nursing staff, managers, care coordinators and housing staff and focus on agreeing actions that will get the patient moving to the most appropriate care or accommodation.

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Services Director

"We no longer just rely on traditional ward reviews because we now have a system to prioritise the daily actions that need to be completed to move people on," explains Treacy.

"Instead, ward managers and lead clinicians have five to seven minute discussions with staff about individual patients to address daily issues immediately and with positive action, focusing on exactly what needs to be done, when and by whom.

"Everyone knows what their responsibilities are, and if someone in the chain doesn't do what they have agreed to do within an acceptable time, their inaction is addressed transparently and they are supported to prevent further delays to the patient.

"This has empowered staff to be creative and take the initiative when it comes to finding solutions to the needs of our service users when they are well enough to be discharged, for example securing B&B recovery houses for service users who don't have a secure home to go to.

"We have also seen how the new approach encourages patient resilience: service users know from early on in their care what services will be put in place for them throughout their stay and once they are discharged. This level of transparency, clarity and cooperation helps them to accept and cope more easily with the journey ahead of them.

"Before, everything was internalised and the trust bore its bed blocking issue in isolation; QFI has brought the focus of accountability on these issues beyond the organisation, stimulated awareness and encouraged partnership and cooperation to do things differently.

"The positive impact on efficiency and quality of service has been significant: we are now able to create internal inpatient capacity every working day."