Mental Health Services in Brighton and Hove

Model of Care

1. Summary

1.1 Around 1 in 4 people experience some form of mental health problem in the course of a year. Anxiety and depression are the most common forms of mental health problems and over the last 20 years there has been a significant increase in the number of people supported by mental health services and the vast majority of care is now provided outside hospital.

1.2 Where care is provided in hospitals there has been a trend towards shorter stays. Many mental health problems are chronic conditions and inpatient care is often part of an overall package of ongoing care and support taking a life-course approach.

1.3 There is significant variation in hospital bed usage across the country and recent investigation by Community Care has highlighted concerns that some parts of the country have reduced hospital bed numbers too far without reinvesting sufficient resources in community services.

1.4 Whole system modelling work undertaken in 2009 highlighted Brighton and Hove as an outlier with higher than average bed usage[1] and scope to shift the balance of care to provide more care in the community and less in hospital.

1.5 This paper provides recommendations for the ongoing model of mental health care in Brighton and Hove for adults with functional need e.g. depression, psychosis. The model for dementia care is excluded from this paper.

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[1] The bed usage figures have been adjusted for population need e.g. Brighton and Hove has on average higher mental health need than other parts of Sussex but when data is adjusted to reflect need; the data shows higher than expected bed usage.

2. Background

2.1 In 2009 a whole system review was undertaken of the demand and capacity for acute mental health beds in Sussex. The key findings for Brighton and Hove were:

- Higher than average lengths of stay when compared nationally
- Delayed discharges

2.2 The review highlighted opportunities to redesign mental health services and provide better quality care by providing more services in the community to:

- help prevent admission in the first place; and
- facilitate earlier discharge from hospital.

2.3 The key recommendation of the review was that if services could be redesigned the overall number of acute mental health beds for the Brighton and Hove population could be reduced from 95 to 76; a reduction of 19 beds.

2.4 Since 2009 health commissioners (formally Brighton and Hove City PCT) and from 1 April 2013 Brighton and Hove Clinical Commissioning Group (CCG) have been working collaboratively with Sussex Partnership NHS Foundation Trust (SPFT) the main local provider of mental health services to make the system changes to reduce the need for acute beds.

2.5 At the HOSC meeting on 16 November 2011 it was agreed to temporarily reduce the number of beds on a phased basis to test out whether the system could safely operate with fewer beds. This agreement was contingent on:

- flexibility to re-open beds should the need arise[2] and
- the plan being overseen clinically by a Clinical Review Group chaired by Dr Becky Jarvis, GP clinical lead for mental health and with Consultant Psychiatrist representation from SPFT from Brighton & Hove inpatient and community services.

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Link to minutes attached http://present.brighton-hove.gov.uk/mgConvert2PDF.aspx?ID=37574

2.6 The 19 beds have been temporarily closed since January 2012 which has provided an opportunity to test the system and make further improvements and investment in community services.

2.7 The key consideration for the Clinical Review Group has been the need to ensure that wherever possible a local bed is made available for anyone that needs one. It is recognized that there will be periods where demand for access to beds surges, both within Brighton and Hove and across Sussex and therefore the standard set for access to a bed within Brighton and Hove is 95% of all admissions. A small number of people also choose not to receive care locally and it may also not be clinically appropriate for some to be admitted to the local hospital.

2.8 The Clinical Review Group is now in a position to make recommendations about the preferred option for the ongoing model of care for mental health services in Brighton and Hove.

2.9 This paper provides a summary of:

- The improvements & changes that have been made to services and pathways since January 2012
- The performance against key metrics, in particular the ability to access a local bed.
- The recommendations for the ongoing model of care for mental health services in Brighton and Hove.

3. Improvements to Community Mental Health Services

3.1 The temporary closure of the beds has enabled funding to be released from the "variable costs" associated with a ward (for example staff, drugs, equipment). This funding has been invested to make further improvements to the community services.

3.2 The total annual costs associated with the 19 beds that have been temporarily closed are £1.6 million. This is made up of variable costs (approximately 50%) and fixed costs (building and overhead costs) approximately 50%. Whilst the beds have temporarily been closed; the ward has been kept empty in case of the need to re-open. This has prevented alternative usage of the ward and is an opportunity cost.

3.3 The variable costs associated with the beds have been re-invested into community mental health services. Specific improvements that have been made from this funding source as well as additional CCG funding in mental health services is detailed in sections 3.4 to 3.9.

3.4 Crisis Resolution Home Treatment Team (CRHT). This team provides intensive crisis support to people living in the community who may otherwise be likely to be admitted to inpatient care and also facilitate early discharge from hospital. The service is provided 7 days a week and is a national evidence based model of care. An additional six nursing posts have been recruited to increase capacity and support more care at home. This investment has enabled the team to provide care for 100 more people at home in a year. The CRHT Team target has increased from 724 to 824 completed treatment episodes.

3.5 **Additional Care Co-ordinators.** An additional seven care co-ordinators have been funded to help reduce case loads and enable more preventative pro-active care. Five out of the seven additional posts have been recruited to substantively and the remaining two posts have been filled by temporary staff. This has enabled the average Care Co-ordinator caseload to decrease from 38 to 28. The posts that are still vacant have now been advertised.

3.6 Enhanced Brighton Urgent Response Service. This enhanced service provides a 24/7 urgent response service to patients at high risk. It was established on 14 January 2013, initially on a pilot basis (until 31 March 2014) to test out the model of care and make any necessary adjustments. It aims to provide a streamlined urgent response to crisis with care provided in community settings wherever possible. An interim evaluation has been undertaken in August 2013 which shows that more patients are being provided with an immediate response when in crisis. Further work is being planned to ensure greater awareness of the service and maximize the opportunity for individuals to benefit from the service. A full evaluation is in progress and this will be considered by the CCG in December 2013 to inform ongoing commissioning of the service from April 2014 onwards.

3.7 **New Accommodation Support Services**

The CCG and Brighton and Hove City Council (BHCC) undertook a joint procurement process to increase capacity for mental health accommodation support for a range of different needs from high intensity complex needs to tenancy support for individuals in rented accommodation. It is anticipated that this increased capacity will help prevent unnecessary delays in terms of discharge from hospital. The total capacity is to support 120 individuals (20 replacing an existing contract with SPFT) and additional capacity to 100 individuals. The

contracts that have been awarded are and are due to start in February 2014. The full detail is contained in a paper to the HWOSC in December 2012.[3]

3.8 **New Day Centre for People with Personality Disorder**. The Lighthouse Day Centre based in Hove opened on 20 May 2013. This new day centre provides intensive 7 day a week support in the community targeting support to people with a diagnosis of personality disorder who have had admissions to hospital. It is not unusual for people with this diagnosis to have multiple admissions over a period of time. The Lighthouse is aiming to provide community based support and reduce admissions and length of stay in hospital. The service has already proving to be successful in terms of numbers attending and plans are under consideration to develop the service to provide an enhanced level of crisis support

3.9 **Summary of Service Developments**

A summary of community developments are detailed in Figure 1 below. The total investment value is £2.6 million per annum. £2.1m has been funded through redesign of existing mental health resources with £0.5 million of new resources.

Figure 1: Summary of Service Developments

	Annual CCG Investment	Start Date	Notes
CRHT	£429,000	April 2013	Funded through release of variable costs associated with temporary bed closure
Care Co-ordinators	£329,000	April 2013	Funded through release of variable costs associated with temporary bed closure
Personality Disorder Development	£715,000	May 2013	Funded through redesign of services plus £142,000 of additional funding
Brighton and Hove Urgent Response Service	£391,000	January 2013	New CCG funding
Accommodation Support Contracts	£718,000	February 2014	Funded through redesign of existing resources. Additional capacity for 100 individuals.
Total	**£2,582,000**		

[3] Link to the Paper is at the attached http://present.brighton-hove.gov.uk/Published/C00000728/M00004126/AI00029442/$Item45app1MHAccomwithsupport.docA.ps.pdf

4 Update on Performance

4.1 Access to Acute Mental Health Beds.

The Clinical Review Group set a target of at least 95% of patients being able to access a bed in Brighton and Hove. The demand for acute beds is variable with relatively small numbers of patients requiring admission at any one time. In 2012-13 there were 752 acute mental health admissions related to Brighton and Hove residents which relates to approximately 2 admissions per day. Since January 2012 when the beds temporarily closed, **93%** of people have been able to access a bed within the City. Performance has not significantly changed from the preceding period when the beds were open but the target of 95% has not been achieved. Due to the relatively small numbers of admissions, fluctuations in terms of numbers of Brighton and Hove residents admitted out of area occur on a weekly basis. In addition there are distinct patterns of seasonable fluctuation in demand with greatest demand for beds from April to June a second peak in December/January. Over the last two years the number of residents admitted to a bed outside of the City has ranged from zero to 16. Figure 2 shows the ability to access acute mental health beds in Brighton and Hove and Figure 3 shows the location where Brighton and Hove residents have accessed a bed when one has not been available in the City.

Figure 2: Access to Acute Mental Health Beds in Brighton and Hove

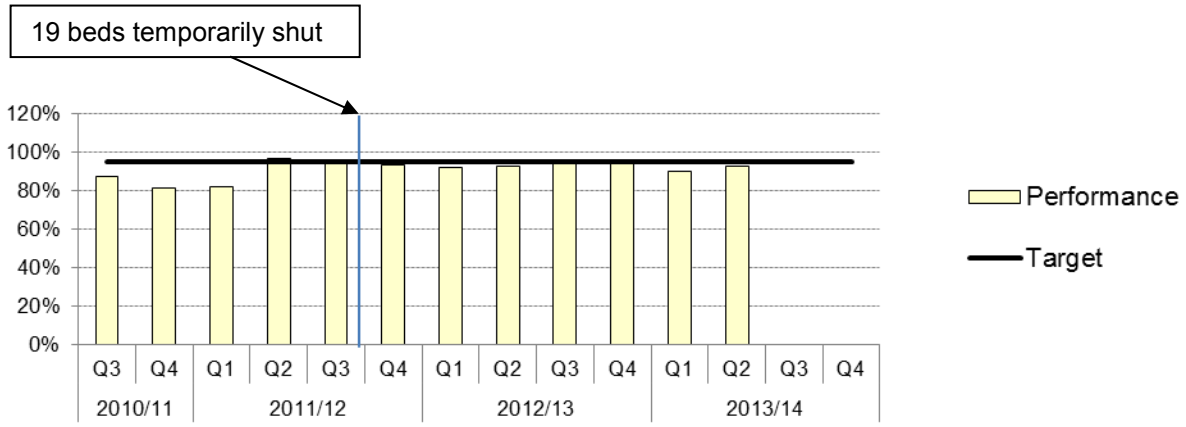
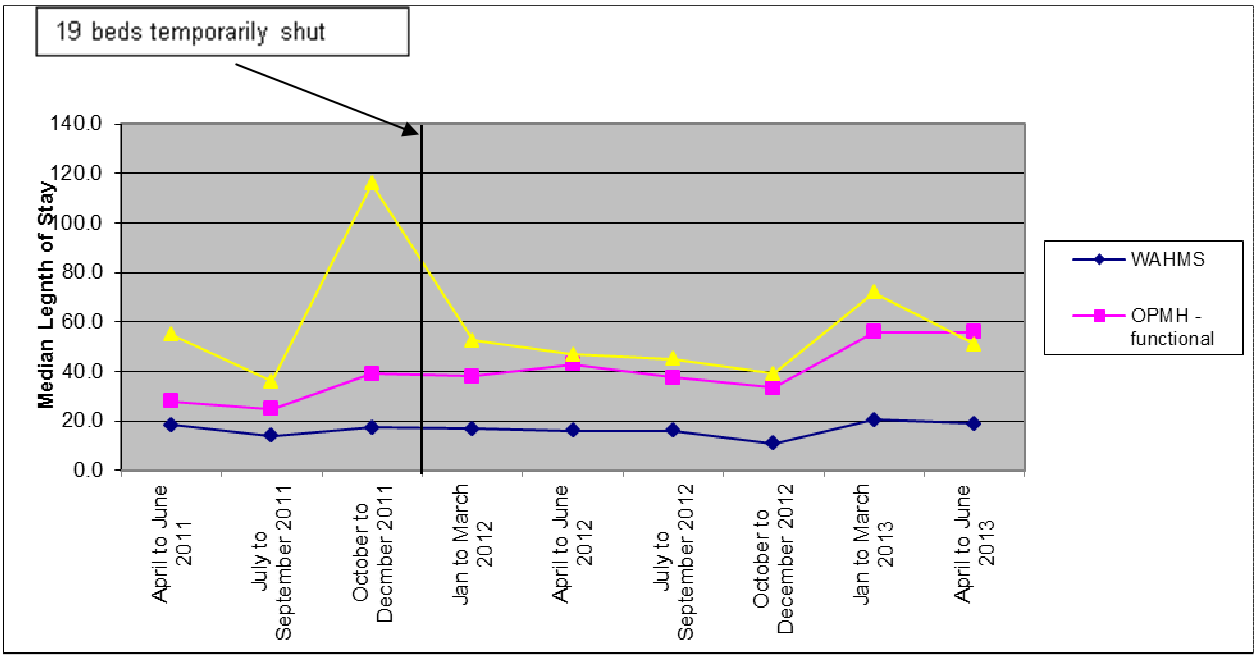


Figure 3: Location of Acute Mental Health Admission for Brighton and Hove Residents (January 2012 until September 2013)

Location of Hospital	Usage (% of Total Bed Days)
Brighton and Hove Hospital	92.6%
Other NHS Hospital in Sussex (Eastbourne, Crawley, Worthing, Hastings)	7.0%
Hospital Outside Sussex	0.4%
Total	**100%**

4.2 **Length of Stay.** Delayed transfers of care were highlighted as a significant issue in the original 2009 whole system modeling. Median length of stay has not altered significantly since the beds have been temporarily been shut and it is anticipated that the additional accommodation support described in section 3.7 will enable people to move on from hospital when they are ready and prevent any unnecessary delays. Figure 4 details the median length of stay.

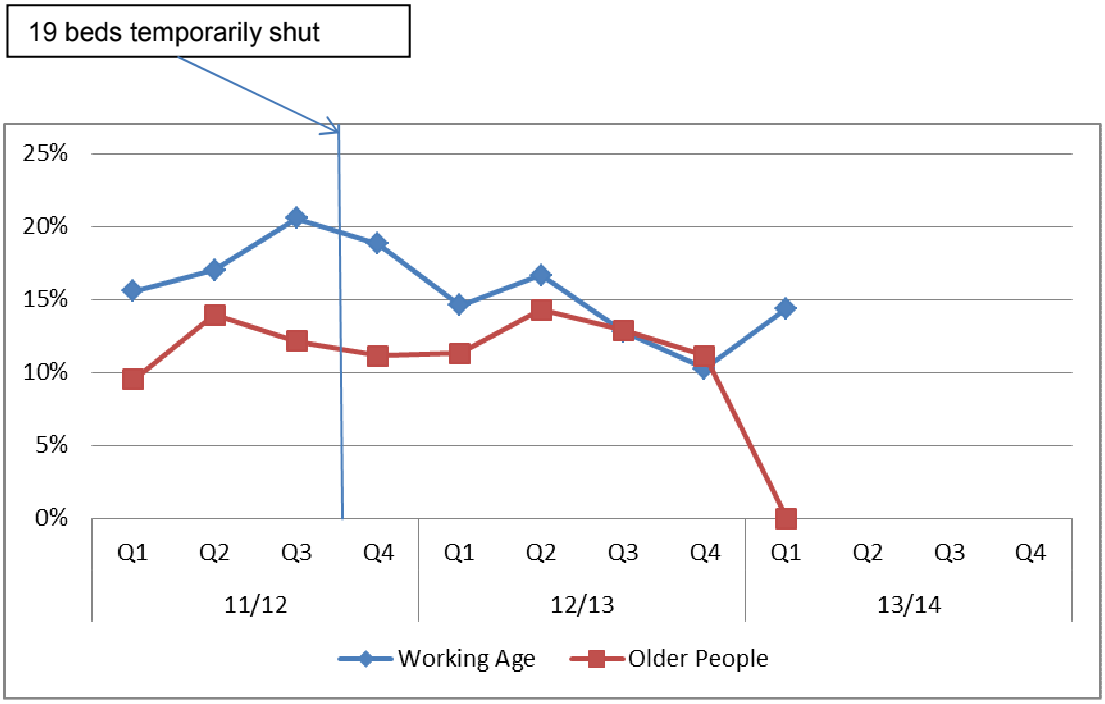
Figure 4: Median Length of Stay



Key
WAHMS: Working Age Service - patients aged18-64
OPMH - functional: Patients aged 65 and over a functional mental illness
PPMH – organic : Patients with dementia

4.3 **Re-admission Rates**. One of the potential risks of reducing length of stay is that patients are discharged too early and end up needing to be re-admitted. The Clinical Review Group have also been monitoring re-admission rates and these have slightly decreased since the beds have been temporarily been shut. Figure 5 shows the trends in re-admission rates.

Figure 5: Re-admission Rates



4.4 In addition to monitoring the performance metrics the Clinical Review Group have also considered a range of soft intelligence from health and social care practitioners delivering mental health care. Issues that have been identified include:

- Approved Mental Health Professionals [4] in Brighton and Hove have highlighted that where a local bed is not available, the assessment process can take longer and patients have at time been detained without an identified bed.

[4] AMHPs are responsible for organising, co-ordinating and contributing to Mental Health Act assessments. It is the AMHP's duty, when two medical recommendations have been made, to decide whether or not to make an application to a named hospital for the detention of the person who has been assessed.

- The consolidating of clinical expertise on the Millview site that has been created through the temporary closure of the ward at the Neville Hospital is seen as beneficial in terms of delivery of high quality clinical quality.

5. Analysis & Discussion

5.1 The decision to temporarily close the 19 beds has provided an opportunity to test the system. Ongoing investment has been made in community services; that aims to provide as much early intervention as possible closer to home and this is the desired overall model of care for mental health. In addition to early intervention community care provides intensive support before and after discharge from hospital to ensure a co-ordinated and safe care pathway.

5.2 Within a community focused model of care, when an acute mental health bed is needed then it is essential that one is made available. It is also desirable that wherever possible this bed should be available locally. The experience since January 2012 is that for over 9 out of 10 Brighton and Hove residents requiring an acute inpatient admission a local bed has been found. However due to the fluctuation in demand there are times but this isn't happening frequently enough.

5.3 In addition is the demand for particular type of beds are not predictable on occasions there are greater demand for male beds and at other times the pressure is for female beds.

5.4 Admission to an acute mental health bed outside the local area has disadvantages from a number of perspectives. Firstly there is the inconvenience for the patient and their carers/families and friends in terms of transport and visiting. There is also a risk that patients who not formally detained under the mental health act chose not to be admitted unless it is to a local bed. There is also evidence that patients admitted out of area end up having a longer length of admission as there can sometimes be difficulties ensuring streamlined continuity of care with local community services when a patient is ready for discharge. Finally there is cost of administrative time spent sourcing beds and the increased financial costs of paying for beds outside the NHS.

5.5 Pressures on acute mental health beds have been noted across the country. The recent Community Care investigation raised concerns at a national level about mental health beds being closed without making further investment in community services. Within Brighton and Hove, senior psychiatrists through the Clinical Review Group have overseen the process of bed closures to ensure that it is clinically safe and to develop sufficient community services as alternatives to hospital admission.

5.6 The Clinical Review Group has been meeting regularly since 2012 to oversee changes to the system and monitor performance in particular the ability to access a local bed. Through analysis of the data it has been identified that at times more beds are needed

than we have locally, but there has never been an occasion when there has been need for 19 more beds in Brighton and Hove.

5.7 The Clinical Review Group has considered a range of options to address this. Figure 6 shows a summary option appraisal.

Figure 6 Option Appraisal

Option	Advantages	Disadvantages
1) Retain Status Quo – with Beds Temporarily Closed	• Flexibility to open beds retained	• Opportunity costs associated with the empty ward • Patients will continue to be admitted outside Brighton and Hove
2) Re-open the Beds	• Additional bed capacity will be made available locally	• Cost associated with opening whole ward • The ward could only be single sex and therefore not always accommodate the demand, which can fluctuate between male and females • Investment from community services will need to be diverted to pay to re-open the ward. • No guarantee that beds will all be used for Brighton and Hove residents given similar system pressures in Sussex
3) Secure additional bed capacity in Brighton Hove (to be funded through release of the funding associated with the empty ward)	• More local beds then are currently available • More cost effective than opening a whole ward • Flexibility in terms of access to male and female beds • Maintains recent investment made in community services • Enables further evaluation of the model of care • Flexibility to cover seasonal pressures	• Not always able to guarantee that Brighton and Hove residents will be able to access a local bed

5.8 The clinical review groups view is that option 1 is not viable on an ongoing basis as there is sufficient intelligence to demonstrate that at times more local beds are needed. In addition there is a financial cost associated with keeping the ward temporarily closed. The funds could be spent more productively to invest in additional bed capacity and/or making further investment in community services.

5.9 Options 2 and 3 are to increase local bed capacity and of these two options the Clinical Review Group is recommending option 3 as the preferred option as it allows for greater flexibility to respond to the variation in demand and also crucially allows maintenance of the recent investment in community services.

5.10 In summary, the recommendation of the clinical review group is option 3 is the preferred option and they will support the plans for alternative use of the current empty ward on the condition:

- All funding associated with the 19 beds that has not already been invested in community services is ring fenced specifically for further investment in local mental health services.
- The Clinical Review Group continue to have responsibility for overseeing the next phase of the plans and that the membership and terms of reference of this group is reviewed to ensure they are fit for purpose.

5.11 The CCG and SPFT have formally agreed to the ring fencing of the funds to pay for:

- Additional bed capacity that will be secured from the Priory Hospital in Hove – initially for a three month trial period from November 2013 and
- Additional investment in community mental health services in Brighton and Hove.

6. Recommendation

6.1 The HWOSC is asked to note the recommendation of the clinical review group to release the funds associated with the ward that has been empty since January 2012 to:

- secure additional local acute mental health bed capacity and
- invest further in local community mental health services.