Mental Health Services in Brighton and Hove

Update on Model of Care

March 2015

1. Background

1.1 In September 2014 an update was provided to the HWOSC about the model of care for mental health in Brighton and Hove following whole system modelling work that indicated there was scope to shift the balance of mental health care to provide more care in community settings. Further detailed information regarding the background is contained in Appendices A & B.

1.2 Acute mental health bed capacity in Brighton and Hove has been reduced in line with the strategic direction to provide more community based care and funding released from closing acute mental health beds has been ring-fenced for re-investment in:

- Community mental health services.
- Additional local acute mental health bed capacity to respond flexibly to fluctuations in demand.

1.3 This paper provides a summary of:

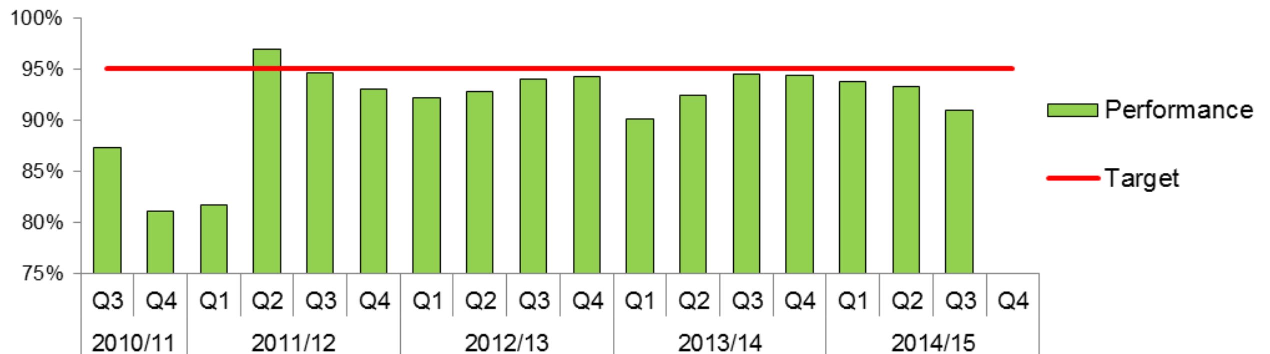
- Bed usage and the impact of the additional flexible capacity secured from the Priory Hospital, Hove.
- Progress against the further development of community mental health services.

2. Access to Acute Mental Health Beds

2.1 The key aim in terms of quality of care for Brighton and Hove residents is to ensure that wherever possible a local bed is made available. Placing people in hospitals out of area can have a detrimental impact on patient and their families / carers experience. It is recognised that there will sometimes be periods where demand for access to beds surges and the local target is 95% of all admissions to be to a Brighton and Hove bed.

2.2 Over the year there has not been a substantial change in performance in terms of access to local beds, although Q1 – Q3 shows a gradual decrease in performance of 3%. The number of residents admitted to a bed outside the City in any week has ranged from zero to fourteen.

Figure 1 below shows trend in terms of access acute mental health beds in Brighton and Hove.



2.3 In the last year, since 1 April 2014 a total of 1513 bed days have been within the private or independent sector. Fourteen patients have been admitted to the Hove Priory Hospital since April 2014. Demand has been predominantly for male beds and often these individuals have additional complexities around risk, dual diagnosis with substance misuse issues, forensic histories, failed accommodation and tenancies all of which impact on length of stay. Some of them in addition require a Psychiatric Intensive Care Unit (PICU).

2.4 Whilst the Hove Priory has been able to provide some additional local capacity it has not had the effect of preventing all out of area admissions. This is largely due to other system pressures for mental health beds including the demand at the Hove Priory by private patients as well as demand for NHS beds from other NHS Trusts across the South East. In addition, on most occasions referrals to the Hove Priory were declined on grounds of risk and acuity and it does not provide a PICU since October 2014 55 referrals have been made to the Priory, only 8 were admitted.

3. Update on Improvements to Community Mental Health Services

3.1 A range of improvements have been made to community services including

- Additional care co-ordinator posts to reduce case-loads.
- Additional posts in the crisis resolution treatment team.
- The establishment of the Lighthouse Centre for people with personality disorder.
- 120 additional units of additional supported accommodation.

3.2 All services are fully operational and continue to provide additional capacity in the community.

3.3 In the paper submitted to HWOSC in September 2014 (detailed in Appendix B) a range of further service improvements were described which aim to

- Reduce the need for in-patient admission.
- Reducing the length of stay for inpatient admission where clinically appropriate.
- Reduce demand for A&E.

3.4 A summary of progress against each of these follows.

3.5 **Enhancement to the Urgent Care Service.** From 9th March an enhanced service known as the Mental Health Rapid Response Service is in place which:

- Provides a simple single access point for urgent response – including a 24/7 phone line.
- Provides extended face to face services until 10pm in the evening.
- Expansion of the remit to include capacity for short term case management (up to 5 days) to support appropriate onward transfer.

3.6 **Improving Access to Psychological Therapies** for patients with psychosis An additional psychologist has been recruited and it is too early on to quantify their impact. However we will be working towards improving timeliness of access for psychological therapies in ATS working closely with triage and formulation in ATS.

3.7 **Increased Capacity at the Lighthouse Centre for People with Personality Disorder.** The Lighthouse Centre was established in May 2013 to provide 7 day a week support in the community targeting people with a diagnosis of personality disorder[1] who have had admissions to hospital. The service has proved

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[1] Personality Disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others.

The main symptoms are:

- being overwhelmed by negative feelings such as distress, anxiety, worthlessness or anger
- avoiding other people and feeling empty and emotionally disconnected
- difficulty managing negative feelings without self-harming (for example, abusing drugs and alcohol, or taking overdoses) or, in rare cases, threatening other people
- odd behaviour
- difficulty maintaining stable and close relationships, especially with partners, children and professional carers
- sometimes, periods of losing contact with reality

Symptoms typically get worse with stress. People with personality disorders often have other mental health problems, especially depression and substance misuse.

Source: NHS Choices - http://www.nhs.uk/Conditions/personality-disorder/Pages/Definition.aspx

successful and a waiting list has built up and so additional investment was put in to increase the number of treatment places by 10. There is evidence that since the service has been set up that there the number of inpatient admissions for people with a diagnosis of personality disorder, has reduced particularly for females.

3.8 **Improved Discharge Planning for Acute In-patient Services.** Bed occupancy is affected by both the number of admissions as well as the length of stay and the original modeling work highlighted Brighton and Hove was an outlier in terms of higher than average length of stay. Many patients in the acute inpatient services have accommodation needs. Overall the city has seen an increased rise in the number of homeless of 40% from 2010 and pressure on the accommodation pathway from inpatient care remains. Improvements to the care pathway have already been made in terms of increased supported accommodation capacity and increased Crisis Resolution Home Treatment Team (CRHT) capacity but there is still potential to reduce median length of stay by making further improvements to the pathway.

3.9 In any given month 30-40% of patients discharged from acute inpatient care in Brighton and Hove were not known to mental health services at the point of admission which creates challenges in terms of the ability to arranged onward care and treatment in the community Plans were agreed for the:

- **Development of 2 Link Nurse for the Assessment and Treatment Service**. These new community based link nurses would attend ward reviews and support the inpatient teams to agree discharge plans. They would agree the ongoing community care treatment plan including identification of the right ongoing referral pathway. It is anticipated that the Link Nurses will help ensure quicker discharge from hospital by ensuring the right treatment plan is put in place as quickly as possible. This is particularly important given the relatively high proportion of people discharged from hospital who are not known to mental health services. Unfortunately is has not been possible to recruit to the two posts. Following initial difficulties in recruitment one post has been recruited with an imminent start date and another post offered and waiting for confirmation of appointment.

- **Increased psychological therapy to inpatient beds and CRHT. Additional 2.1 WTE.** The CRHT did not have any dedicated psychological therapy input and the acute ward input is limited at two sessions a week. Additional investment has been put in place in the CRHT to support holistic assessment and treatment planning to support recovery as well as development crisis and care plans in the community with the aim of supporting people at home. Additional psychological input to inpatient care will help improve the quality of care through the development of appropriate treatment plans and it anticipated that this will impact in terms of reducing length of stay. The additional post on the Caburn ward started in January and

the CRHT post started in March. Again it is too early to quantify the impact of these posts. The psychologist in the Caburn Ward is working closely with Lighthouse to further enhance the relationship between acute wards and Lighthouse to prevent admission by the creation of innovative care plans and risk assessments and to support reduced admissions. In addition additional psychology resource in the dementia team is also benefitting patients in Meridian Ward.

- Additional technician resource in the hospital (0.5 WTE) will enable routine physical health checks to be undertaken and help speed up processes in inpatient services This post has been advertised and shortlisting is taking place currently.

There was user involvement in the development of the proposals throughout the process of agreeing the priority areas for investment. In addition a focus group was set up to consider how best to market and communicate about the changes to the urgent care pathway. Feedback from this group is currently being used to inform the development of marketing material about the service

4 Financial Summary

4.1 £1.8 million of funding per annum has been released from the closure of the beds and reinvested mostly in community services. £50,000 of this is being ring-fenced to continue to buy additional flexible local capacity at the Hove Priory to respond to surges in demand. A breakdown of the financial summary is detailed in Table 3 below.

Table 3: Financial Summary

	Investment	**Annual Investment Value (£)**
1	Care Co-ordinators	£329,000
2	Crisis Resolution Home Treatment Team	£429,000
3	Lighthouse Centre (including additional capacity)	£425,000
4	Enhancement of the urgent care pathway	£283,000
5	Psychological Therapy Capacity for people with psychosis	£64,000
6	Improved Discharge Planning for Acute Inpatient Services	£220,000
7	Hove Priory – Additional Inpatient Capacity	£50,000
	TOTAL	**£1,800,000**

5. Summary

5.1 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 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 when this isn't possible. The additional local bed capacity secured from the Priory Hospital Hove has been helpful at times when there are surges in demand but hasn't completely prevented the need for all out of area admissions. Wherever possible SPFT does try to accommodate people in Trust beds, where this has not been possible the Trust works hard to repatriate patients and works closely with external providers to facilitate this as quickly as possible.

5.2 Despite ring-fencing funding for additional investment, difficulty in recruitment has meant delays to the start date of some additional service capacity. The vast majority of new posts have however now been recruited to with only 2 of these not yet having started.

Future Plans

6.1 Moving forward Brighton and Hove City Council and Brighton and Hove Clinical Group have developed plans as part of the Better Care Programme to integrate care across the City.

6.2 Programmes of work focused on Frailty and Homeless have been established and mental health is integral to both of these programmes. The development of multi-disciplinary care teams based around GP practices will provide the opportunity to ensure people with mental illness can receive more support in the community and have better co-ordinated holistic care that addresses both their physical and mental health needs. The new Substance Misuse services from April 2015 include an integrated model of care for those with dual diagnosis, and have both mental health and substance misuse needs. The new model of care includes the co-location of substance misuse and mental health staff, to strengthen the delivery of an integrated care model. Further updates on the progress of the Better Care Programme will be provided to the HWOSC at regular intervals.

Appendix A

HWOSC Update – November 2013

HWOSC Paper
November 2013 FINA

Appendix B

HWOSC Update – September 2014

HWOSC Update - Beds - September 20: