Brighton & Hove City Council

Health & Wellbeing Overview & Scrutiny Committee

Title:	**Health & Wellbeing Overview & Scrutiny Committee**
Date:	**25 March 2015**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Rufus (Chair)C Theobald (Deputy Chair), Bennett, Bowden, Cox, Marsh, Meadows and Sykes **Co-optees:** Reuben Brett (Youth Council), Robert Brown (Healthwatch) and Colin Vincent (OPC)
Contact:	**Kath Vlcek** 01273 290450 kath.vlcek@brighton-hove.gov.uk

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26 Procedural Business **1 - 2**

To consider

(a) Declaration of Substitutes

(b) Declaration of Interest

(c) Declaration of Party Whip, and

(d) Exclusion of Press and Public

27 Minutes of Previous Meeting **3 - 10**

28 Chair's Communications

29 Update on Homeless Healthcare **11 - 16**

Contact Officer: *Alistair Hill, Consultant in Public Health* *Tel: 01273 296560*

Ward Affected: *All Wards*

30 Update on Mental Health Service Provision in Brighton & Hove **17 - 24**

Information from Brighton and Hove Clinical Commissioning Group attached

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Date of Publication 17 March 2015

Agenda Item 1

To consider the following Procedural Business:

A. Declaration of Substitutes

Where a Member of the Committee is unable to attend a meeting for whatever reason, a substitute Member (who is not a Cabinet Member) may attend and speak and vote in their place for that meeting. Substitutes are not allowed on Scrutiny Select Committees or Scrutiny Panels.

The substitute Member shall be a Member of the Council drawn from the same political group as the Member who is unable to attend the meeting, and must not already be a Member of the Committee. The substitute Member must declare themselves as a substitute, and be minuted as such, at the beginning of the meeting or as soon as they arrive.

B. Declarations of Interest

(1) To seek declarations of any personal or personal & prejudicial interests under Part 2 of the Code of Conduct for Members in relation to matters on the Agenda. Members who do declare such interests are required to clearly describe the nature of the interest.

(2) A Member of the Overview and Scrutiny Commission, an Overview and Scrutiny Committee or a Select Committee has a prejudicial interest in any business at a meeting of that Committee where –

(a) that business relates to a decision made (whether implemented or not) or action taken by the Executive or another of the Council's committees, sub-committees, joint committees or joint sub-committees; and

(b) at the time the decision was made or action was taken the Member was

(i) a Member of the Executive or that committee, sub-committee, joint committee or joint sub-committee and

(ii) was present when the decision was made or action taken.

(3) If the interest is a prejudicial interest, the Code requires the Member concerned:

(a) to leave the room or chamber where the meeting takes place while the item in respect of which the declaration is made is under consideration. [There are three exceptions to this rule which are set out at paragraph (4) below].

(b) not to exercise executive functions in relation to that business and

(c) not to seek improperly to influence a decision about that business.

(4) The circumstances in which a Member who has declared a prejudicial interest is permitted to remain while the item in respect of which the interest has been declared is under consideration are:

(a) for the purpose of making representations, answering questions or giving evidence relating to the item, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise, BUT the Member must leave immediately after he/she has made the representations, answered the questions, or given the evidence;

(b) if the Member has obtained a dispensation from the Standards Committee; or

(c) if the Member is the Leader or a Cabinet Member and has been required to attend before an Overview and Scrutiny Committee or Sub-Committee to answer questions.

C. Declaration of Party Whip

To seek declarations of the existence and nature of any party whip in relation to any matter on the Agenda as set out at paragraph 8 of the Overview and Scrutiny Ways of Working.

D. Exclusion of Press and Public

To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: Any item appearing in Part 2 of the Agenda states in its heading the category under which the information disclosed in the report is confidential and therefore not available to the public.

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls.

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

4.00pm 4 FEBRUARY 2015

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Rufus (Chair)

Also in attendance: Councillor C Theobald (Deputy Chair), Bennett, Bowden, Cox, Marsh, Meadows and Sykes

Other Members present: co-optees from Healthwatch; Older People's Council; Youth Council

PART ONE

23 PROCEDURAL BUSINESS

23.1 There were no declarations of substitutes.

23.2 Councillor Bowden declared an interest in Item 27, he has carried out some work for the Health and Social Care Information Centre.

23.3 There were no declarations of party whip.

23.4 Press and public was as per the agenda.

24 MINUTES OF PREVIOUS MEETING

24.1 The minutes of the previous meeting were agreed. Councillor Marsh commented on the item reporting on the PLACE inspection of the Eye Hospital, she has attended there recently in a personal capacity and wanted to record her thanks for the excellent service that she had received.

Councillor Theobald also drew Members' attention to the free Healthchecks that were being offered.

25 CHAIR'S COMMUNICATIONS

25.1 Sussex Community Trust had sent HWOSC a letter for information- they will be introducing a managed parking scheme at their Elm Grove site. The letter would be circulated to members for information.

25.2 There had been a pan –Sussex health scrutiny meeting at Sussex Partnership Foundation Trust; minutes would be circulated in due course. SPFT are holding a 2020 vision event on Friday 6 February, all were invited to attend.

25.3 The Chair welcomed the new representative for the Older People's Council, Colin Vincent.

26 INTRODUCTION TO THE CARE ACT

26.1 Philip Letchfield, Head of Modernisation and Performance, Adult Social Care, gave a presentation on the Care Act.

26.2 Mr Letchfield said that the Care Act would bring the biggest change to statutory duties since 1948, it was the consolidation and modernisation of a great deal of existing legislation. It is bringing some existing policy into statute including safeguarding and personalisation. It is also introducing new legislation. It does not cover the Mental Health act or Deprivation of Liberty legislation. Most of the Act is due to come into effect in April 2015, with the remainder in April 2016.

The guidance guides people through the customer journey from the first contact. It is very person centred, it does not talk about 'services' but it is about users, with choice and control the main drivers.

26.3 The key changes for April 2015 include:

1 – the local authority has to meet a person's needs when they are deemed 'substantial'. Brighton and Hove City Council (BHCC) already works to this standard
2 – Carer's eligibility – the threshold for assessment and support is significantly reduced but Brighton & Hove has been taking an active approach to identifying and supporting carers for several years.
3 – Safeguarding – BHCC already has most of these elements in place
4 – Independent advocacy; this is new
5 – Deferred payments - BHCC has had this in place for two years, the only change is the Council can now charge an administration fee and interest on the loan.

26.4 The funding of care will change in April 2016, in response to the Dilnott enquiry. There is currently a limitless cost to care but the indications are that from 2016 people will not pay more than £72000 for care in their lifetime. For people who eligible care needs when they reach 18 years of age there will be no charges for care in their lifetime. The cap is on care costs not total costs, the resident in care homes will stay pay up to £12000 per annum for associated costs.

The cap will not be retrospective; costs will start accruing in April 2016. Everyone who wishes to be included will have to have a Care Account, following an assessment by BHCC social workers; predictions are that there will be another 2000 people who will be eligible for assessments in 2016.

Funding towards the care cap will be based on the usual cost that BHCC will pay, so if the care home is above that threshold, the resident will not count towards the cap. This has led to discussions with providers which are likely to continue.

26.5 The threshold at which the local authority makes a financial contribution is also changing. Currently if people have over approximately £23000 in assets, the council does not have a duty to make any contribution. From April 2016, this threshold will rise to £118000 – if someone has less than this in assets, the council will have some contribution.

A report has been presented to the Health and Well Being Board re charging for services, it is not proposed to charge carers for support services.

Finance modelling has taken place to assess the ten year impact of the Care Act. Every local authority has been given £125,000 to help with the implementation in 2014/15.

26.6 Locally, the Modernisation Board meets every fortnight to plan the implementation of the Care Act, with a number of workstreams and actions shared with the Better Care Fund. There are a number of elements that have been put in place and that are still to be implemented, including increasing the online offer, increasing training and development for staff, mapping the business processes and a need to engage with people who had not previously been eligible for assistance.

26.7 Members commented and asked questions:

- In response to a query about the scope of the Act, Mr Letchfield said that the Care Act applies to England only. There is guidance given for situations if people move cross-border.
- There will be an administration fee to set up deferred payment schemes and interest will be interest charged
- The CCG currently fund the free nursing care element of nursing home places and there are no plans to change this
- Members queried what would happen to people with low/ moderate needs. Mr Letchfield said that investment in preventative services is a key part of the strategy. They are looking at how to work in partnership with the CCG and Public Health amongst others
- Members asked how users were involved in setting up the implementation systems and how user feedback was incorporated? Mr Letchfield said that there has been user group testing of information provision, which will be a sustainable model going forward. There are regular bulletins and a communications campaign to include user involvement information.
- Members asked whether the £125000 was ringfenced; Mr Letchfield confirmed that it was. The money is to enable programme management and is for this year only.

26.8 The Chair thanked Mr Letchfield for his presentation –clearly the budgetary implications would be of concern to the whole council so he asked Mr Letchfield to circulate the financial modelling figures when they are available. This was agreed. The presentation was noted.

27 ADULT SOCIAL CARE PERFORMANCE MONITORING

27.1 Philip Letchfield presented a report on Adult Social Care performance. He explained that the performance framework had been dramatically changed in recent years, where existing performance measurements had been scrapped. The new system is based on sector-led improvements. BHCC has performed very well on the annual user survey results.

Mr Letchfield said that the council took part in a number of voluntary engagement events, including the City Summit and events in Jubilee Library to reach as wide a range of people as possible. Mr Letchfield said that they were all very valuable schemes but they did have a resource implication so they would be reviewed on a case by case basis.

With regard to the Local Account document, Mr Letchfield said that this had moved from being a purely data driven piece to include more case studies and personal stories. This change had been made following user feedback.

27.2 Members commented and asked Mr Letchfield further questions:

- How many people completed the user survey? Mr Letchfield said that there was a response of between 400 – 450 returns which gives a statistically representative response
- There was a discussion about the Delayed Transfer of Care figures. It was pleasing to see the improvements in service. Denise D'Souza, Executive Director, Adult Services, commented that last year was a particularly good year. This year was more challenging as the system was working at full capacity. There was still positive news – on average people are coming out of hospital care six days earlier this year than last year.
- How do we compare with East Sussex County Council in Delayed Transfers of Care? Mr Letchfield said that East Sussex was not part of BHCC's comparator group, but that Adult Social Care works closely with colleagues across West and East Sussex to share information and learning.
- Members asked whether care providers paid the Living Wage (rather than minimum wage)? Ms D'Souza said that when the contracts were retendered, the commitment to paying a Living Wage was included in the tender. This would be included in future tendering processes. However it should be noted that the council does not have any influence over contract arrangements for residential care.
- Ms D'Souza also commented that 'sector-led' improvement was very challenging, and neighbouring authorities would be ask to report on one another, there is a robust infrastructure. HWOSC members might like to hear more about this at a later date, to understand benefits and weaknesses in the system. This was welcomed.

27.3 The Chair thanked Ms D'Souza and Mr Letchfield for the report and agreed to table a report on sector-led improvement at a future meeting.

28 CCG REVIEW INTO PREMATURE MORTALITY

28.1 Kate Gilchrist, Head of Public Health Intelligence, and Dr Katie Stead, GP Lead for Primary Care Quality and Public Health presented a report with their initial findings into premature mortality in the city. The audit has involved all of the GPs in the city, which is the first time that all practices have agreed to be involved in a piece of research in this way.

The audit had focussed on three diseases, diabetes, chronic obstructive pulmonary disease (COPD) and cardio-vascular disease. Brighton and Hove has a higher mortality rate from causes considered preventable than England and the South East, and in particular under 75 mortality from respiratory disease. Each person who had died before the age of 75 of one of these diseases has had their medical records audited; there is now an in depth audit of each person's GP notes to add further information. The emerging themes from the in practice audit confirms some of the trends that had been identified in the first wave of research. There is a trend of socially isolated patients, with high incidence of depression.

Ms Gilchrist and Dr Stead presented some very early findings to HWOSC members; these included a link to deprivation although this was not the only contributing factor. There were higher rates of deaths for men between 55 and 74. In all categories, smoking, obesity and alcohol consumption rates were higher than average. Exception reporting was also high for those with diabetes and COPD.

Some actions have already come out of the audit; these include extra funding of Health Trainers by Public Health and the Clinical Commissioning Group, bringing the total to ten FTE health trainers. There has also been some peer to peer information sharing, for example looking at practices with low levels of exception reporting.

28.2 Members commented on the report and asked questions:

- Members asked for more information on health trainers. Ms Gilchrist said that health trainers are very successful at engaging with men on health matters as well as people from more deprived areas – two key groups identified in the audit. They offer behaviour change programmes. There is a national evidence base for their effectiveness and cost effectiveness.
- How do you measure deprivation? Ms Gilchrist said that they use the index of multiple deprivation, to assess areas in groups of 1500 households.
- Has average life expectancy increased or decreased over time and can this be made available online? Ms Gilchrist said that on average, life expectancy has increased by three months per year. Inequalities have reduced for the first time. Life expectancy at small area level is already available through the partnership data site http://www.bhconnected.org.uk/content/local-intelligence
- Members asked work with licensing, given the links with alcohol consumption? Ms Gilchrist said that public health was working increasingly closely with licensing now that they are part of the same Directorate under Tom Scanlon, the Director of Public health, and the team are involved in monitoring and addressing alcohol consumption. For example with the public health alcohol licensing framework, Dr Scanlon giving evidence at licensing, and input to the policy review. There is a Healthy Weight programme board too, which is looking at healthy food matters.

- Members asked whether drug consumption was assessed? Ms Gilchrist said that it had not been particularly high, though it was notable in the homeless practice.
- Will the audit be extended to other diseases? Dr Stead said that it was not planned at present as the current audit still has a lot more work to undertake. Ms Gilchrist said that there had recently been a separate cancer audit so it was not included here and there are annual audits for drug related deaths and deaths from suicide.
- Dr Stead commented that NHS England are using this audit as a way of showing other CCGs how to address health inequalities as part of a series of regional workshops.

28.3 The Chair thanked Ms Gilchrist and Dr Stead and wished them luck with the further audit and outcomes.

29 HEALTHWATCH BRIGHTON AND HOVE - ACHIEVEMENTS OVER THE LAST TWELVE MONTHS

29.1 Frances McCabe, Chair of Healthwatch Brighton & Hove (HWBH) spoke to HWOSC members about their work over the last 12 months. She explained that HWBH has a small staff team, working to build relationships with partners to influence health provision. There are a large number of volunteers, who feed back intelligence to the wider organisation. HWBH has a place on the Health and Wellbeing Board.

HWBH has worked on a number of local health issues including most recently the closure of the Eaton Place GP surgery.

HWBH has a statutory right to Enter and View premises; they have just done this at Royal Sussex county Hospital, along with East Sussex Healthwatch. They have taken part in PLACE inspections of hospital sites; following concerns that they raised about the Eye Hospital, a large refurbishment programme was introduced.

Other aspects of HWBH's work includes a helpline, which tends to receive calls about primary care; they have a large research database, which they use to ensure that no issues are being overlooked – the scrutiny of the database led to recent work on CAMHS. HWBH has set up a Community Interest Company.

29.2 Members commented and asked questions:

- How does HWBH make sure it doesn't become part of the health system? Ms McCabe said that she is always explicit about the fact that she is there to reflect the voice of the service users. HWBH can be sympathetic of service pressure on organisations but they are in place to speak for users.
- How do you prioritise your work? Ms McCabe said that HWBH looks at all of the data and intelligence available, listens to soft intelligence and makes a priority decision. Some of their client groups are given higher priority for example older people who are vulnerable and isolated.
- How does HWBH avoid duplication with other health watchdogs? Ms McCabe said that it was decided by whether HWBH could have an impact on an issue.
- Members asked whether Ms McCabe was getting sufficient support from paid staff as she is contracted for part time hours only. Ms McCabe said that it is a small staff team

with a lot of demands to attend meetings. It is hard to balance everything out, but it is an ongoing issue.

- Where are the completed reports publicised? Ms McCabe said that it is included on the HWBH website and circulated to partner organisations. They send any recommendations to the main organisations at an early stage to see whether they can be incorporated to their work plans. If the recommendations are taken up, this is reflected in the final report. If you have a good working relationship with a provider, helpful criticism can have a positive impact on their working practices.
- Ms McCabe added that there is more potential for HWOSC and HWBH to synergise their work from a user perspective; it was agreed that she would meet with the HWOSC Chair to discuss this further.

29.3 The report was noted and Ms McCabe thanked for her attendance.

The meeting concluded at 6.30pm

Signed Chair

Dated this day of

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 29 Brighton & Hove City Council

Subject:		**Update on Better Care Homeless Programme**
Date of Meeting:		**25 March 2015**
Report of:		**Alistair Hill, Consultant in Public Health**
Contact Officer:	**Name:**	**Alistair Hill** **Tel: 29-6560**
	Email:	**alistair.hill@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The Overview and Scrutiny Committee conducted a review of hostels in 2014. The recommendations advised that

- Given the significance of homeless people in terms of city health inequalities, we welcome the fact that the Health & Wellbeing Board is taking an active interest in the health and social care needs of this group. We are very interested in the progression of this work, and request that the HWB's plans for homeless healthcare be presented to the HWOSC for comment within the next 12 months.

2. RECOMMENDATIONS:

2.1 That the Health and Wellbeing Overview & Scrutiny Committee note the development of the Better Care programme to improve health outcomes of homeless people and develop an integrated health and care system.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Brighton and Hove Better Care Plan describes how services for our frail and vulnerable population will be improved to help them stay healthy and well, and will be more pro-active and preventative, and promote independence.

3.2 The plan draws on a wide range of experience and evidence of best practice both locally, nationally and internationally, and includes the views of local service users, their families and carers and local stakeholders. In Brighton & Hove a broad definition of 'frailty' has been adopted. As part of this broad approach improving health and care outcomes for homeless people has been identified as a priority.

3.3 Rough sleeper numbers fluctuate but the estimate in March 2014 was 132. The count is always lower and found 41 rough sleepers in November 2014.

3.4 There are approximately 400 homeless households in emergency accommodation, 370 single people in temporary accommodation, 500 single homeless people living in hostels and other supported accommodation, and an unknown number squatting and sofa surfing. Homelessness has increased by nearly 40% from 2010.

3.5 Nationally 13.5% of the general population attend A&E or an outpatient appointment compared to 39% of the Brighton & Hove homeless audit sample who attended A&E or an outpatient appointment (homeless health needs audit 2014). Over a 12 month period it is estimated only 7% of the general population will have an inpatient hospital stay compared to 25% of the homeless audit sample who had been admitted to hospital at least once in the last 6 months (homeless health needs audit 2014). Over 80% of homeless patients report having at least one physical health problem for 12 months or longer. Nationally, the average age of death in the homeless has been estimated as 47 years in men and 43 years in women.

3.6 The Joint Strategic Needs Assessment for 2014 and Brighton and Hove Homeless Health Audit highlighted the poor health and wellbeing outcomes in single homeless people locally[1]. There is a high prevalence of mental ill-health, drug and alcohol dependency and physical health need amongst the homeless. In addition there is high use of unplanned healthcare and low uptake of preventative services. Based on national and international evidence it is anticipated that a more integrated and flexible model of care, based around the needs of individuals rather than services of settings of care, will improve access to planned health and care, resulting in a reduced reliance on emergency and unplanned care, and better outcomes.

3.7 A Homeless Integrated Health and Care Board was established in 2014 with the vision " to improve the health and wellbeing of homeless people by providing integrated and responsive services that place people at the centre of their own care, promote independence and support them to fulfil their potential". Membership of the Board includes representatives from BHCC (adult social care, housing, public health), the CCG and NHS Trusts, a GP from Morley Street Homeless Healthcare, community and voluntary sector, Sussex Police and service user representation.

3.8 The Board is developing an integrated health and care model for the homeless population of the city by April 2016. A Multi Disciplinary Team (MDT) approach is being developed, led by primary care. This will work alongside service users to provide integrated, co-ordinated and personalised care. Key aspects include:

- Hosting specialist health and related services in a central hub, based around a specialist general practice
- Multi-disciplinary team providing outreach services in hostels and other settings, and inreach services to health services including hospital care.
- Care planning and case management.
- Involvement of service users in co-design of services

[1] http://www.bhconnected.org.uk/sites/bhconnected/files/jsna-6.4.3-Rough-sleepers2.pdf

3.9 Whilst the integrated care model is being developed, care and support to homeless people has been strengthened. Progress has been made in co-ordinating care through establishing multi-disciplinary team meetings and trialling service delivery through pilot projects, including the Sussex Community Trust Hostels Collaborative Project and Pathway Plus projects.

3.10 The Collaborative Hostels pilot project was commissioned following the publication of a Homeless Health Audit conducted by Public Health and Housing in 2013, which highlighted the high level of health needs amongst the city's hostel population. The service is based on a proactive and in-reach model of care delivered by a multi-disciplinary team including nursing, occupational therapy and physiotherapy.

3.11 The team has been supporting service users in hostels with a high level of previously unmet complex health care need across a wide range of physical health and long term conditions. A total of 73 referrals were received in the first 6 months of 2014/15 and 81 residents have received a service. Overall a high level of engagement with health care has been achieved including high levels of registration with GPs.

3.12 The Pathway Plus project (originally funded by Department of Health in October 2013 to March 2014) is improving the care planning and co-ordination of care of homeless people admitted to hospital, and improving discharge care planning and follow up in the community. The project is delivered by a partnership involving Pathway, St Johns Ambulance and Justlife Foundation.

3.13 The project has worked with A&E and hospital wards to improve the identification of those who are homeless and admitted to hospital. For all those identified the team has provided comprehensive care and discharge planning.

3.14 Looking ahead for 2015/16 Better Care funding has been approved to enable the continuation of the pilot projects, and to strengthen MDT working.

3.15 A key priority is securing the links with mental health and substance misuse services. Additional resource has been secured to enable these links to be built over the next interim year, The mental health homeless team will be a key member of the Homeless Primary Care led MDT and will help to develop the psychological model of support and mental health clinical care pathways and standards for the homeless population.

3.16 The new Substance Misuse Services (SMS) contract will be implemented from April 2015 and an integrated model of service delivery is included within the contract. For Dual Diagnosis, four substance misuse dual diagnosis staff will be co-located with the mental health teams, to improve access to treatment and care and to ensure that care is delivered in partnership including: assessment and risk profiling, shared care planning and review. Links with the SMS services including the Dual Diagnosis workers and the Homeless model of care will be built in the next interim year. .

3.17 In 2015/16 a business case for the long term model for homeless care will be developed as part of the Better Care programme. This will be planned alongside the current and future Housing Related Support services commissioned by BHCC. There will also be an emphasis on health and wellbeing outcomes in the retendering process for these services.

3.18 Also in 2015, a pilot is running at New Steine Mews hostel regarding the use of Personal Health Budgets for homeless people, and delivery of health checks (commissioned by Public Health) is being piloted in hostels.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not applicable

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 Service user engagement has been central to the development of the developing service model to improve care.

6. CONCLUSION

6.1 A programme of work is underway to support improving outcomes in homeless people including supporting them to stay healthy and well, providing more proactive and preventative services

6.2 The overall aim is to provide a health, care and support package to vulnerable homeless people in a way which extends beyond their accommodation to provide ongoing continuity and ensure information between services is shared to improve the outcomes for people. They will also have a named care coordinator who will be the lead professional and cases will be discussed at weekly MDTs. The work to improve the health and wellbeing of homeless people will be more effective with all agencies working together with a lead professional with improved coordination from Housing ASC, mental health and substance misuse services.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None specifically for this report. Financial implications are considered within the Better Care Programme.

Legal Implications:

7.2 None specifically for this report.

Equalities Implications:

7.3 None specifically for this report. An EIA for the developing model will be conducted later in 2015.

Sustainability Implications:

None specifically for this report.

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:

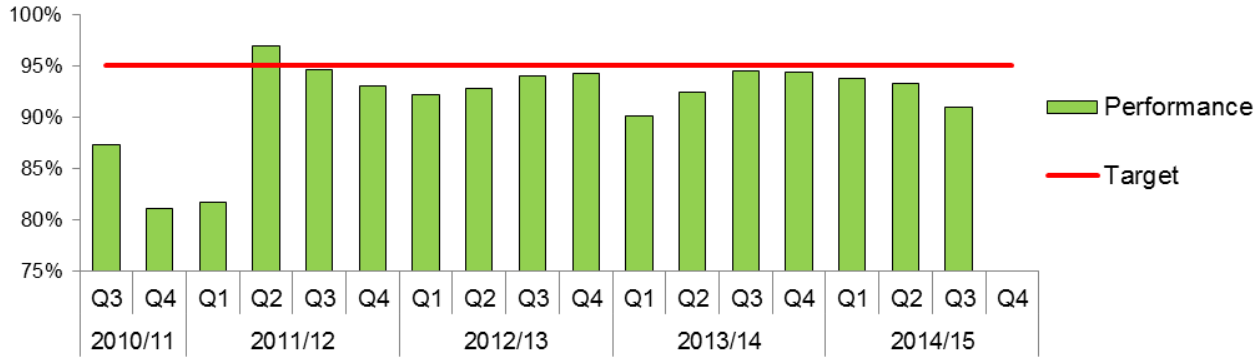
- Bed usage and the impact of the additional flexible capacity secured from the Priory Hospital, Hove.
- Progress against the further development of community mental health services.

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

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