Mental Health Acute Beds

HOSC Update - June 2012

1. PURPOSE OF THE PAPER

The purpose of this paper is to update the HOSC regarding the proposals to reduce the number of acute mental health beds in Brighton and Hove.

2. BACKGROUND

Previous papers have described the rationale for the proposals and the agreed local approach to ensure the arrangements are implemented safely. The HOSC has given its support to proceed with a temporary phased reduction in bed numbers with the agreement that a Clinical Review Group will oversee the process and provide updates to the HOSC.

3. PROGRESS

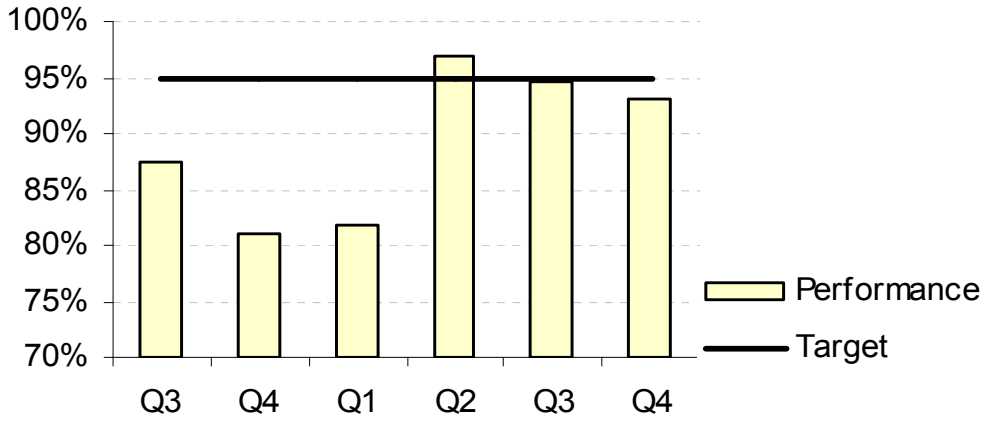
3.1 The Clinical Review group have held four meetings to date. The purpose of the group is to assess the point at which there have been sufficient system changes to enable 19 beds in Brighton and Hove to close on a permanent basis.

3.2 The Clinical Review Group has agreed a range of clinical metrics that will be monitored and measured to assess whether the system is ready for the beds to close. The metrics are detailed in Appendix A. An update on progress against key metrics are as follows:

3.3 **Access to Beds in Brighton and Hove**.

One of the key metrics is that **95%** of residents are able to access a bed within the City. This equates to no more than 3 Brighton and Hove residents being admitted out of area at any one time (excluding female psychiatric intensive care where there is no local facility). The data contained in figure 1 plots the trend from Q3 2010 (September to December 2010) until the most recent quarter (January to March 2011). It shows that during the most recent quarter that this target has not yet been achieved – the proportion of bed occupancy within Brighton and Hove is at **93%**. There is also softer intelligence that some residents who agree to an informal admission, chose not to enter hospital treatment, if the available bed is not within Brighton and Hove. A potential negative impact is that a patient's condition could deteriorate whilst they are waiting for a local bed to become available and it may take longer for them to recover once they are admitted.

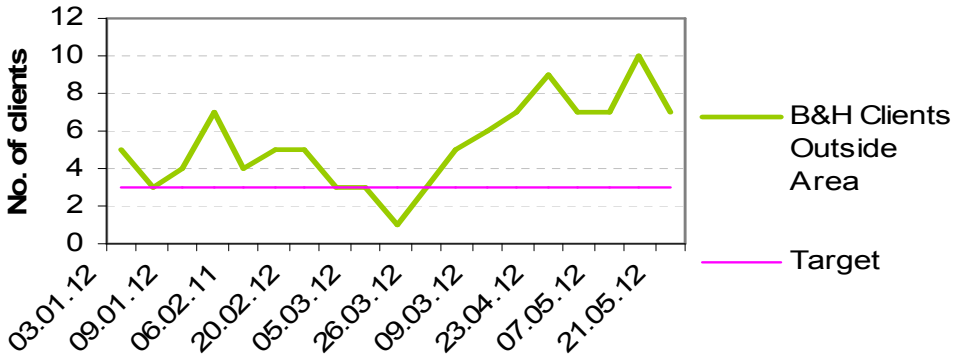
Figure 1: Proportion of Occupied Bed Days that are located within Brighton and Hove



Note
Data excluded female psychiatric intensive care unit – as there is no local facility.

More detailed data for the period since January 2012 (figure 2 below shows that the target of no more than 3 Brighton and Hove residents has only been achieved for 5 out of the 19 weeks (26% of the time). However it needs to be recognised that within the data for admissions outside Brighton and Hove included are small numbers of people where this is appropriate e.g. (a patient still registered with a Brighton and Hove GP but living in another part of Sussex, or because they are member of Millview Hospital staff, or because of patient choice).

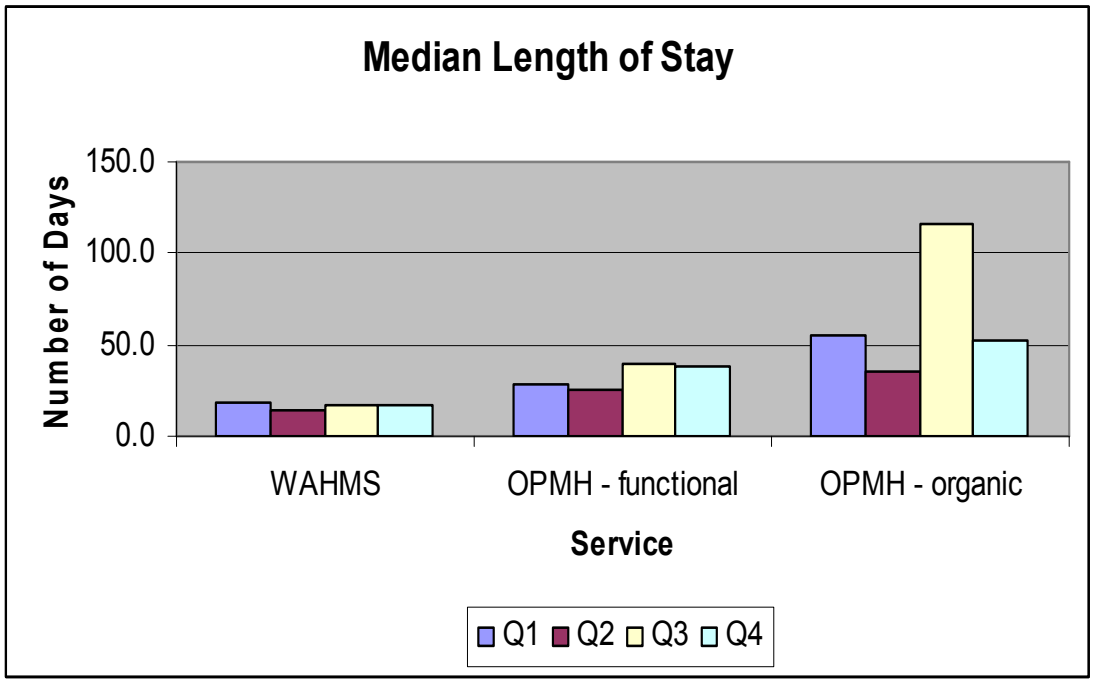
Figure 2: Number of B&H Residents Admitted Out of Area



3.4 **Length of Stay**

Median Length of stay has fluctuated, with increases shown in older people services for the last two quarters of 2011-12. The data is detailed below in Figure 3.

Figure 3: Median Length of Stay



Notes
WAHMS – Working Aged Mental Health Service
OPMH – Older People Mental Health Service

3.5 Delayed Transfer of Care

The target is for delayed transfers of care to be no more than 5%. For working aged service the figure has stayed at 5% or below during 2011-12, but for older people the target has not been achieved for quarters 3 and 4 of 2011-12. Lack of suitable supported accommodation remains one of the key reasons for delayed transfer of care.

Figure 4 – Delayed Transfer of Care – Working Age Services

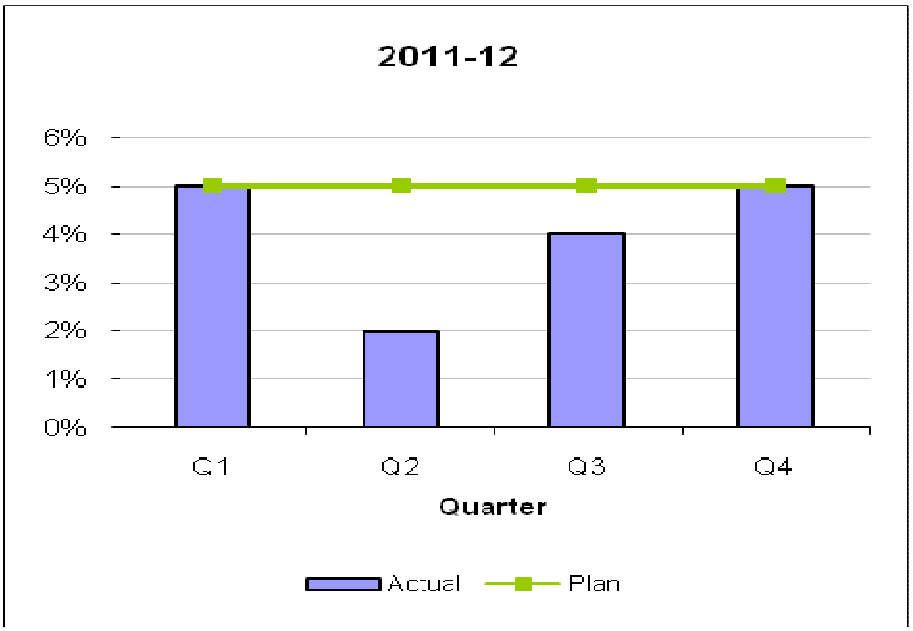
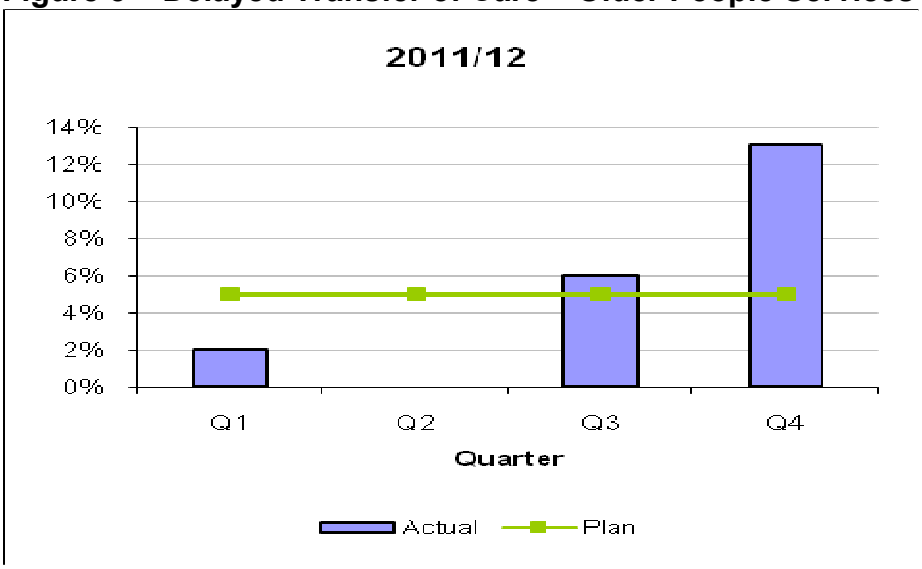


Figure 5 – Delayed Transfer of Care – Older People Services



3.6 **Re-admission Rates**

Re-admission rates appear to have increased in 2011-12 compared with the previous year for working age services (figure 6).The pattern appears to be more variable in older people services (figure 7). Sussex Partnership Foundation Trust (SPFT) is undertaking a more detailed clinical audit to examine and understand this issue in more detail.

Figure 6 – Re-admission Rates – Working Age Services

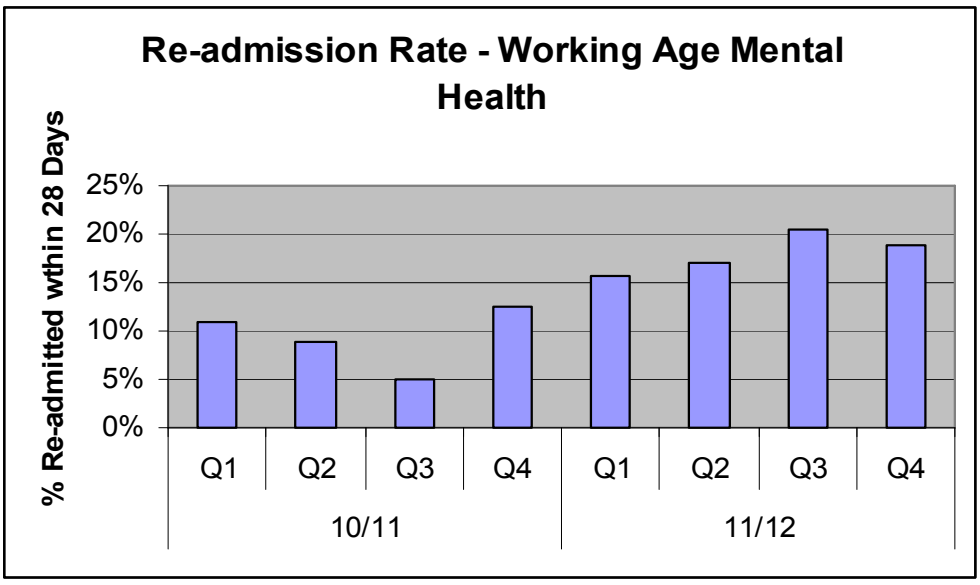
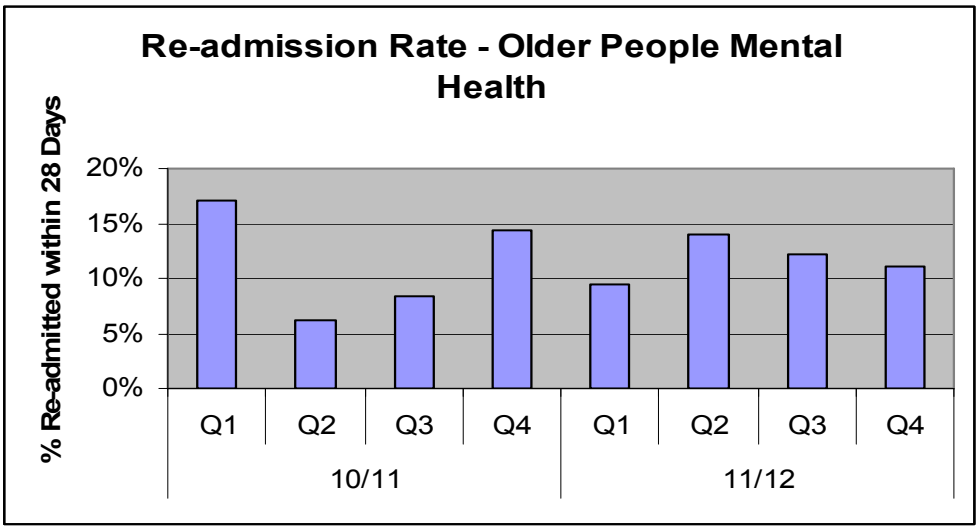


Figure 7: Re-admission Rates – Older People Services



3.7 Complaints & Serious Untoward Incidents (SUI's)

Over the period September 2011 to April 2012 a total of 31 complaints were received by SPFT relating to Millview Hospital and urgent care services in Brighton and Hove. Three of these related to access to beds

- Long wait in A&E for assessment and delay in admission due to bed availability.
- Two people raised concerns about admission outside of Brighton and Hove.

All three complaints have been investigated and responded to.

In addition there has been a recent unexpected death of a patient being care for by the crisis team. This SUI is in the process of being investigated. Part of the scope of this investigation will include attempting to establish whether the incident had any connection with inpatient bed availability.

4. PLANS TO ENHANCE COMMUNITY MENTAL HEALTH SERVICES

There a further updates to report on two important ongoing pieces of work that will contribute to the reduction in number of admissions and the length of stay:

4.1 Development of a community based service for people with personality disorder. We have reached agreement to develop a new community based facility which will help support people with personality disorder in the community and prevent some hospital admissions. The new service will start in April 2013. SPFT will provide the overall management of the service as well as the clinical aspects of service delivery. The CCG is currently inviting bids via our Commissioning Prospectus for the community and voluntary sector to provide a range of supporting activities such as peer support and volunteering opportunities, and a range of social and therapeutic activities.

4.2 **Improvement of Supported Accommodation** Delayed transfers of care due to housing still remains a significant issue. Bench-marking work undertaken in 2012 has identified opportunities to secure improved value for money from the funding available for mental health accommodation support. During 2012 the CCG plan to under-take a procurement process and re-commission an increased number of units of supported accommodation to help prevent delayed transfers of care due to insufficient support accommodation. It is anticipated that increased accommodation units will be available from June 2013.

4.3 In addition to the updates on these two developments, SPFT have undertaken a review of the crisis resolution home treatment team (CRHT) and the team will be working more closely with the wards to help facilitate early discharge from hospital. These changes will be introduced on a three month pilot basis and the effectiveness will be evaluated.

5. SUMMARY

Since January 2012, 15 beds have been temporarily closed at Millview Hospital whilst we have been testing out the safety of the system in terms of operating with fewer beds and also to undertake refurbishment work. A range of metrics have been agreed via the Clinical Review Group and it is evident that the targets have not yet been achieved. The two key developments that have been identified as supporting the bed closures (increased units of supported accommodation and a community based personality disorder service) will not be available until 2013. The fundamental question for the Clinical Review group to consider and agree at the next meeting on 3rd July is whether the beds should re-open until these key developments are in place.

6. RECOMMENDATION

The recommendation of the clinical review group is that the system is not yet ready to close beds on a permanent basis. The clinical review group at its' next meeting on 3rd July will consider whether the beds should re-open until further improvements to community mental health support services are in place.

Appendix A

CLINICAL METRICS

	Description	Target	
1	Access to Bed in Brighton & Hove	95% of patients able to access bed in the City	
		Length of wait for CRHT assessment	
		Length of time between the decision to admit & the time a bed is identified	
2	Average Length of Stay	WAHMS	28 days
		OPMH - functional	50 days
		OPMH - organic	60 days
3	Median Length of Stay	WAHMS	
		OPMH - functional	
		OPMH - organic	
4	Admission Rates	WAHMS	73 per 100,000 weighted population
		OPMH - functional	48 per 100,000 weighted population
		OPMH - organic	106 per 100,000 weighted population
		Variation in admission rate over the course of the year	
5	Re-admission Rates	No increase in the emergency re-admissions rates (no of emergency re-admissions within 28 days)	
6	Delayed Transfer of Care	Less than 5%	
7	Impact on Recovery Teams	7 Day Follow Up from discharge from CRHT	
8	Impact on CRHT Team	CRHT caseload To be agreed following output of CRHT review	
9	Number of complaints		
10	Number of Adverse Incidents		
11	Number of SUI's		