Agenda Item 7

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**10th March 2011**
By:	**Director of Governance and Community Services**
Title of report:	**Improving Mental Health Services in East Sussex**
Purpose of report:	**To consider progress with the development of mental health services for adults in East Sussex.**

RECOMMENDATIONS

HOSC is recommended to:

1. **Support the recommendations made by the HOSC Mental Health Task Group (appendix 2)**
2. **Request a further progress report in September 2011.**

1. Background

1.1 In March 2010, HOSC considered proposals to make changes to inpatient services for adults, put forward by NHS East Sussex Downs and Weald (ESDW)/NHS Hastings and Rother (H&R) and Sussex Partnership NHS Foundation Trust. In summary, the proposals in East Sussex involved:

- Reducing the number of inpatient beds from 122 to between 92 and 100 (removing 22 - 30 beds) over the next 12-18 months with 3 options for how these are organised.
- Potentially further reducing the number of beds to around 80 in 3-5 years time.
- In the longer term, providing the remaining beds in new facilities in 1 or 2 locations in the county.

Services for people with dementia were not affected by the proposals.

1.2 A public consultation on the proposals took place from 8th March to 8th June 2010.

1.3 At its meeting in March 2010, HOSC agreed that the proposals represented a 'substantial development or variation to services' which requires the NHS to consult with HOSC as outlined in health scrutiny legislation. HOSC also agreed to establish a Task Group comprising Councillors Heaps, Pragnell, Rogers and Tidy to examine the proposals further and put forward a report and recommendations for the Committee's consideration.

1.4 In June 2010, HOSC endorsed an interim report from the Task Group which was subsequently finalised and submitted to the NHS organisations for consideration as part of the decision making process. The finalised report has previously been circulated to HOSC Members and is available on the HOSC website www.eastsussexhealth.org .

1.5 In July 2010, a joint meeting of the Boards of NHS ESDW and NHS H&R considered the proposals. HOSC's report was included within the Board papers. The Boards' decision was to proceed with option 2 as outlined in the consultation document. This option reduces the total number of inpatient mental health beds in East Sussex from 122 to 92. This involves the closure of 20 beds at the Department of Psychiatry, Eastbourne District General Hospital, and a reduction of 10 beds at the Woodlands Centre for Acute Care at Conquest Hospital, Hastings.

1.6 Alongside the changes to inpatient beds, the Boards agreed the introduction of measures for checking that community services have improved and the setting up of a 'Stakeholder Reference Group', to include service users, to monitor improvements to community services.

2. HOSC's recommendations

2.1 The conclusion of HOSC's original report was that the direction of travel outlined in the consultation document was the right one and that there was scope within East Sussex to reduce admissions and improve the way community services work together to better support service users at home. However, the report also highlighted evidence that community services were stretched and that there was a significant amount of work to be done to bring these services to a point where they had the capacity to provide consistently high quality support.

2.2 For these reasons HOSC's recommendations focused on robust and transparent monitoring of the development of community services and a carefully managed approach to implementing bed reductions when the time is right.

2.3 In September 2010, HOSC received a response from NHS ESDW/NHS H&R and Sussex Partnership NHS Foundation Trust which accepted all the Committee's recommendations. The Committee confirmed its support for the changes, subject to the implementation of the recommendations. The Committee also requested that the Task Group reconvene in early 2011 to assess progress, 12 months on from the publication of the proposals.

3. Progress reports

3.1 The HOSC Task Group met in February 2011 to assess progress with the development of mental health services and readiness or otherwise to reduce inpatient beds. In order to undertake this assessment the Committee requested a progress report from NHS ESDW/H&R and Sussex Partnership Trust. A detailed report was supplied, a summary version of which is attached at appendix 1. The full version of the report is available on request. This report addresses the recommendations made in HOSC's report of July 2010.

3.2 Martin Packwood, Joint Commissioning Manager for Mental Health, NHS ESDW/H&R and Lorraine Reid, Chief Operating Officer, Sussex Partnership NHS Foundation Trust, will be in attendance to take any questions on the report.

3.3 The Task Group has produced a report summarising its findings and recommendations to HOSC – attached at appendix 2.

3.4 In summary, the Task Group concludes that, on balance, sufficient progress is demonstrated by the evidence to enable the reduction in beds in line with the proposed timetable. This takes into account the spare capacity currently available in the units and the scope for further improvement. The closure of the beds would enable improvements to be made at the Eastbourne unit, particularly creating the space to relocate the crisis team next to the ward area and making changes to the physical environment in the unit, including improved gender separation.

3.5 This view does not mean that there is no need for further improvement of community services. The Task Group understands the need for further work, for example on the development of integrated care pathways, support for carers and work with GPs. However, the Task Group is not convinced that keeping beds open will have a significant benefit in this regard.

4. Recommendations

4.1 HOSC is invited to support the Task Group's recommendations as set out in its report (appendix 2).

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Background Papers:
HOSC Final Report, July 2010;
NHS consultation document, March 2010.

Appendix 1

N.B. A fuller (25 page) version of this report is available on request from Claire Lee: claire.lee@eastsussex.gov.uk or 01273 481327.

Improving Mental Health Services in East Sussex

Progress Report – 24th February 2011

1.0 Introduction

This Report has been produced in response to the HOSC Task Group's Final Report of July 2010 on the consultation and proposals for 'Improving Mental Health Services in East Sussex'.

It has been produced with the involvement of a 'Stakeholder Reference Group' which was established to review the evidence for progress against commitments given to improve community services, before bed closures took place. There is also an attachment that reports the specific views and concerns of service user and carer members of the Stakeholder Reference Group – attached at Annex A.

The Report focuses on two particular questions:

- are community services sufficiently developed to support bed closures?
- will bed capacity be sufficient to meet future need?

Clearly the two questions are closely interrelated, as community and bed-based mental health services form a 'whole-system' of services that people may need at different times, and the key to their success is the appropriateness of the 'balance' that is struck between these different aspects of services.

There is therefore a judgement to be made - whether sufficient progress has been made such that the 'whole-system' has reached a 'tipping point' and the transition from one 'state of equilibrium' between bed-based and community services to another, is ready to be safely taken.

What is set out in the report is therefore the 'story' not only of how community services have developed and improved in recent years, as well as more specifically since consultation began in March 2010, but also how and why this process will continue.

That this story continues, and plans are in place for on-going developments in community services in the future, should not though detract from the progress that has already been secured against consultation commitments, and that a judgement could be made that these are already sufficient to enable beds to safely close.

The report also therefore sets out how and when beds would close, should HOSC (and PCT Boards) agree in March 2011 that sufficient progress has indeed been made, and approve that the proposed programme of closures goes ahead.

It should also be noted in current financial context, that the ability of mental health services to continue the journey towards more community rather than bed-based services, will to some extent depend on securing savings from bed closures.

2.0 <u>Are the proposals in line with best practice and policy for mental health services</u>?

HOSC rightly refers to the NHS Plan (2000) as setting out plans for the introduction of new community services in the context of there then being few existing alternatives to hospital admission, and indeed a range of evidence-based services designed to sustain the mental health and well-being of people with severe and enduring mental illnesses living in the community. The aim of all of these services in their different ways was to reduce demand on secondary care services and in turn acute hospital beds.

In East Sussex all of these new community services were introduced over the period following the introduction of the NHS Plan, and the investment associated with each is set out below:

Community Services	**Investment Sums**
Early Intervention in Psychosis	£751k
Assertive Outreach	£1.14m
Crisis Resolution & Home Treatment	£3.83m
Health In Mind	£5m
Total	£10.72m

It can be seen that unprecedented levels of investment in community mental health services were seen throughout this period, during which there has been *no reduction* in the numbers of acute in-patient beds being provided across East Sussex.

HOSC also cites the East Sussex 3-year Joint Commissioning Strategy for Mental Health published in early 2008 (08/9-10/11) as setting out an optimum service model based on a 'stepped approach to care', which identified that one particularly outstanding area still to be addressed was mental health in Primary Care and treatment of common mental health problems.

Review of current services (below) demonstrates that this 'gap' has now been addressed, and hence that to all intents and purposes the NSF and NHS Plan (2000) have each been successfully implemented in East Sussex.

In line with best practice guidance, it is only now proposed as a result of this prior investment and its impact on demand for hospital admissions, that the transition can be made between the previously prevailing balance between bed-based and community services, to a new balance of care.

3.0 <u>Will community services be sufficiently developed to support a reduction in inpatient beds</u>?

3.1 Current Services

That all of these services are now in place, and that unprecedented levels of investment have been made in community services over recent years, is not doubted and indeed was acknowledged in the HOSC report.

However, it was also considered that there remained scope for the various services to work more effectively together and that service users, amongst others, felt that

existing community services remained ‘stretched’ despite their considerably greater resources.

In order to understand the progress that has been made in addressing these issues and provide assurance that this progress has and will be maintained, consideration is now given to current services in turn.

3.1.2 Crisis Resolution & Home Treatment Teams (CRHTs)

A great deal of work has been taking place over the last year to review these teams, and ensure they are as effective and efficient as possible.

The primary purpose of CRHTs is to provide intensive home treatment and thereby prevent hospital admission of those who would otherwise require admission, and to facilitate earlier discharge of those who could go home with intensive support.

CRHTs are therefore explicitly charged within national guidance to ‘gate-keep’ all admissions to acute hospitals, in order to ensure that the levels of severity and risk associated with the person being referred merit admission, and that the CRHT is not otherwise able to offer home treatment as a safe and effective alternative to admission. The fulfilment of this gate-keeping role for CRHT is now met in 100% of circumstances in East Sussex.

Nationally defined local targets for CRHTs, in terms of home treatment episodes being delivered, have also been met over many years now, and indeed have been significantly exceeded (1,448 treatment episodes per annum compared to a target of 852) due to the high levels of investment in these teams in East Sussex.

Below we set out the role of CRHTs in sitting ‘between’ all other community and bed based services to better understand how recent changes will significantly further improve CRHT effectiveness in preventing hospital admission and facilitating earlier discharge.

- **Adoption of the ‘functional model’ by Psychiatrists**

Psychiatrists have until recently been ‘patch-based’, that is, they have been responsible for working with defined local populations, and have had responsibility for their patients whether they were living in the community, or were admitted to a hospital bed. Whilst this had the advantage of providing continuity of psychiatrist care whether somebody was at home or in hospital, it also resulted in operational inefficiencies and priorities being to some extent split.

For example, case review and arrangements for discharging their patients was reliant upon the timing of psychiatrists attending acute in-patient units for their ‘ward rounds’, rather than being timed at the earliest opportunity when, for example (with CRHT support), a patient may be ready to go home. This represents an operational inefficiency in the system arising from the organisation of psychiatrist’s roles and responsibilities.

In addition, these arrangements meant that psychiatrists were unable to prioritise and thereby specialise in the practice of community or acute care.

The Royal College of Psychiatrists published guidance on the merits of psychiatrists specialising in community or acute care, (known as the ‘functional model’ for the deployment of psychiatrists), and argued that this would promote more effective (and

efficient) practice in both areas by reducing deterioration, relapse and acute episodes of illness in the community, and by reducing lengths of stay by planning and achieving treatment objectives in hospital with a view to discharge at the earliest opportunity.

In East Sussex this 'functional model' of psychiatrist deployment was first introduced in the Hastings and Rother area, on the re-opening of the Woodlands acute unit (which had been closed on safety grounds due to serious untoward incidents), and has resulted in reduced bed numbers there being able to safely accommodate all those requiring admission.

At the same time the operational base of the local CRHT was moved to the Woodlands unit, and clinical and managerial responsibilities for both acute hospital beds and the CRHT was consolidated in to a single structure – forming a unified 'acute' mental health service.

This has meant that CRHT and hospital staff are able to form much closer working relationships, and offer patients an integrated care pathway from admission to discharge, within which both in-patient and home treatment form closely associated and contiguous parts.

In the ESDW area of East Sussex this model has now also been introduced, with the appointment of psychiatrists to lead the newly unified 'acute' mental heath services, and a re-drawing of patches or areas which will be served by newly designated community-psychiatrists.

It is also intended to co-locate the local CRHT in to accommodation at the Department of Psychiatry (DoP) adjacent to the acute wards, although the timing of this move is dependent upon adopting a programme of bed reductions within the unit, which is required to free-up space for CRHT accommodation. At present the CRHT operational base is on the ground floor of the DoP some distance from the wards.

The adoption of the 'functional model' is one of the most critically important developments for the CRHT, with possibly the single most significant impact on acute bed occupancy.

- **Adoption of 'ageless' Crisis Services**

Access to CRHTs will be extended to all as part of the adoption of an 'ageless' model of services for people with functional mental illness, that will see consistent services being provided to people based on need rather than an arbitrary age level,.

Concerns that this might adversely impact on the ability of these teams to support their existing client group has been reviewed. Efficiency measures have been introduced that have the explicit aim of continuing to reduce inappropriate CRHT referrals and hence increase 'conversion rates' of referrals and assessments to home treatments. This productivity improvement should also mitigate any risk that CRHTs are unable to sustain their provision of alternatives to hospital admission at current (high) levels.

- **The CRHT Review**

The Review reported that CRHTs in East Sussex spend considerable amounts of their time receiving referrals and undertaking assessments of people whose

presenting circumstances did not place them at risk of hospital admission, and hence were inappropriate.

The review then quickly moved on to a review of referral numbers and sources, the proportion of these that went on to obtain an assessment, and in turn the proportion of these that went on to be taken on to CRHT caseloads or admission.

In this way it was quantified that significant amounts of CRHT referral management and assessment time was indeed being spent inappropriately, resulting in CRHT staff being unable to carry out as many home treatments as they would otherwise be able. The sources and causes of inappropriate referrals were therefore investigated.

It was interesting to note that service user review-group members were quick to realise how their perception of how 'stretched' services were, could be attributed as much to inappropriate demands being placed upon them, as to the adequacy of their resourcing.

- **A&E Liaison**

One of the main sources of inappropriate referrals was from the A&E department at Eastbourne DGH. Dedicated A&E Liaison services have now been introduced at Eastbourne DGH. These will provide specialist mental health assessment and support to hospital clinicians 24 hours per day, 7 days a week.

- **Help with 'What to do in a Crisis'**

In acknowledgment of the wider issue that service users and carers need better information about what to do in a crisis, the review group has completed a mapping of all the different circumstances in which services may be approached in a 'crisis'.

Considerable progress has and is continuing to be made in communicating to GPs (including out of hours GP services), what course they should take when presented with people in mental health crisis, and other agencies such as the Ambulance service and NHS Direct are also being contacted to verify and if necessary update their responses.

Clearly with the establishment now of A&E liaison teams at both General Hospital sites across East Sussex, much improved communications between general medical and other hospital based clinical staff will develop, and the next (and final) step that has been agreed by the Review Group, is that an information leaflet is designed and published for wide distribution, that offers advice and guidance to service users and carers on what to do in a crisis.

- **Crisis Accommodation / Sanctuary**

Finally in respect of the crisis care pathway, the Review Group has been considering the role played by the Sanctuary Project located in Hastings. The Sanctuary is a seven bedroom 24-hour staffed house that provides temporary accommodation for people experiencing a mental health crisis.

Although the service is very well liked by its local service users, and representations have been made from service user groups in the west of the county who would like to see a similar scheme established there, it was also found by the Review Group that its precise role and remit had become blurred over the course of its evolution.

As it is also quite an expensive service at just over £1,000 per resident per week it was considered important to re-visit what functions it could and should best serve.

The Review Group has therefore recommended that clarity should be brought to the role and function of the Sanctuary within the crisis care pathway:

- Its primary function should be the provision of temporary accommodation to those who would otherwise be admitted to hospital and for whom a period of home treatment by the CRHT would be a safe alternative, but whose usual residence would be an unacceptable or unsuitable setting for the delivery of such home treatment.

- Admissions and discharges should be ceded exclusively to the CRHT who will use the accommodation in order to deliver home treatment to those whose usual residence is unacceptable or unsuitable.

- Lengths of stay should be brought in to line with those set out in the contracted service specification (and of those receiving home treatment in their usual residence), resulting in a considerable expansion in the annual capacity of the Sanctuary to accommodate people who may need and benefit from it.

- Consideration should be given to whether the Sanctuary should be made accessible to residents from the west of the County who might benefit from it.

Whilst it is recognised that these recommendations fall short of aspirations from some service users (and HOSC), to have a Sanctuary-style service established in the west of the County, this is not a financially viable option available to commissioners at this time.

It is however felt that what is proposed is a good compromise with significant potential to enhance the Sanctuary's role. It is therefore hoped that HOSC will support this approach in difficult circumstances.

3.2.2 Assertive Outreach (AO) Teams

These teams were set up in order target people with severe and enduring mental illness whose sometimes ‘chaotic’ lifestyles meant they tended to disengage from community services. AO teams therefore operate with a small and stable group of patients who are susceptible to this pattern of behaviour. These teams have as a result been successful in preventing relapse and frequent hospital admissions.
In East Sussex there are 180 people on AO caseloads.

3.2.3 Early Intervention in Psychosis (EiP)

EIP teams were fully established from 2009, based on very good evidence that when people first experience psychosis they significantly benefit from care treatment and support from a specialist team, and moreover that it is vital that this continues for a period of three years.

The evidence for this model of service is that outcomes are significantly improved, with patients being able to much better self-manage their symptoms, be less likely to

misuse drugs or alcohol, and be less likely as a result to deteriorate and require hospital admission. In East Sussex there are 168 people on EIP caseloads.

3.2.4 Community Mental Health Teams (CMHTs)

With the advent of EIP teams to treat early onset psychosis, AOT to pro-actively manage and support people with complex needs in the community and CRHTs to provide a rapid response to crisis, many of the functions previously undertaken by generic CMHTs were taken over by these specialist teams.

Relationships between CMHTs and other teams could sometimes become unclear and boundaries between them protected, rather than managed in a seamless and integrated way. The response of generic teams to referrals and to those taken on to caseloads could vary significantly within and between teams depending on the particular skills, experience and interests of CMHT members. Without a clear role and comparable focus and status as was accorded to the new specialist teams, staff morale within CMHTs also came under pressure.

In many ways, the ‘blueprint’ for community mental health services ‘Under One Roof’ as now being implemented in East Sussex continues the trajectory of increasing specialisation and orientation around specific conditions and their complexity. It thereby re-designs and makes far more specific the roles and responsibilities as well as organisation of community services, which had previously been assumed by CMHTs.

These steps are being taken in part in response to difficult financial times as they recognise and address the need to increase efficiency by ensuring that people more often find the right service at the right time in the right place. They will therefore contribute to increases in productivity necessary following the high levels of investment made in expanding the overall quantity of community services in East Sussex.

That these further developments are taking place now should not however detract from the significantly improved performance that has already been achieved by CMHTs, for example in driving down response times from referral to assessment and treatment. They should rather be seen as part of a continuous process of development and improvement that will help ensure community services represent value for money, and hence are financially as well as clinically sustainable.

Existing CMHTs will therefore be reconfigured and replaced by two teams each with specific roles and responsibilities, specialising in particular activities, and having the relevant staff skills and experience appropriate to these functions.

Broadly speaking these will be divided in to two teams:

- one that provides a clinically highly skilled assessment, and specialised staff able to provide evidence based treatment interventions such as psychological therapies, of proven effectiveness in alleviating the assessed / diagnosed needs of the individuals concerned;

- one that provides intensive case management (under the Care Programme Approach or 'CPA'), with a focus on recovery including addressing social problems, for those with the most complex and intractable needs of often long-standing duration. Importantly, the service will operate seven days a

week and into the evenings, to provide improved access for those who are known to services and on team caseloads who may experience a crisis.

This transition will be completed between April and June 2011. Everybody who has been cared for by existing CMHTs will be found a place on the caseloads of one or other of the new teams.

3.2.5 Health in Mind – Primary Care Based Mental Health Services

Having invested in new community services at the higher levels of service intensity within a 'stepped' model of care, national and local policy has increasingly been focusing on preventative services intervening at ever earlier stages in the development of mental health problems.

We know from our strategic needs assessment that one in five of us may experience some form of common mental health problem in any one year and, from the involvement of GPs in our commissioning strategy, that many of these people present in their surgeries and represent a significant proportion of their workload.

As a result it was important that primary care mental health services were put in place to prevent such deterioration taking place, averting the risk of loss of employment and independence for example, and thereby reducing additional demands being placed on specialist services by referral from primary care.

The other important reason for putting in place primary care based mental health services, was to support GPs in the management of people with common mental health problems, and particularly their decision making and referral practice, to ensure that again, people found their way more often to the right service in the right place at the right time

This 'gap' in services available to treat common mental health problems within primary care has now been filled by the introduction in April 2010 of the new 'Health in Mind' service in East Sussex.

Health in Mind Services are made up of:

- Primary Care Mental Health Workers (PCMHWs-22 Whole Time Equivalent (WTE)) who are qualified Mental Health Professionals attached to every GP practice across East Sussex, working wherever possible in surgery premises, and providing GPs with support, information and advice on the management of common mental health problems. They also provide specialist assessment, and facilitate access or referral to appropriate statutory and non statutory services including psychological therapies.

- Psychological therapies operate at 2 levels, High Intensity (Cognitive Behavioural Therapists (CBT) - 44 WTE) and Low Intensity (Psychological Wellbeing Practitioners (PWPs) - 18 WTE), and provide National Institute for Health and Clinical Excellence accredited evidence-based interventions for the treatment of anxiety and depression.

Where this new model of service is working as intended, for example with the full engagement of GPs and embedded in surgeries, it is working well, and GPs are increasingly expressing their satisfaction with it.

This is not to say however, that there have been no problems since it was launched in April 2010. These have included PCMHWs being absent due to sickness, and a period whilst PCMHW roles were not fully understood or assumed, nor their relationships fully developed with their practices. This resulted in excess demand over capacity being placed on services, and a need for improved communication and reporting of utilisation. At the same time, and in part as a result of these same issues, waiting lists for CBT quickly built up, although PWP services are actually under-utilised. As these issues and problems have arisen, Commissioners have agreed actions with the service provider.

It should be noted that all these aspects of the Health in Mind service were designed with the active involvement and participation of local GPs, who continue to exert an increasing influence on the way in which mental health services develop in East Sussex, and their role within care pathways for the care and treatment of people who are on their surgery lists.

In the course of these discussions, it became clear that GPs were concerned about the arrangements for discharge of people from specialist mental health services back to their care. In particular, there was concern that discharged people who had previously been known to specialist mental health services, who relapsed and were referred back, had to wait as long for assessment and treatment as people who had not previously been known to services.

In response to these concerns, a new response time standard of access to assessment within 7 days was introduced by the Trust, specifically for people previously known to their services. This initiative has been very warmly welcomed by GPs. Performance to date against this standard has been extremely high (at 99% - reflecting the importance of it).

3.2.6 Condition-specific Care Pathways

Extending mental health services and resources in to primary care, and continuing the specialisation in community services also now enables the development of more integrated and condition-specific care pathways that had previously been variable due to the generic nature of CMHTs. Work is already well progressed in developing these care pathways.

These developments of integrated care pathways can also be seen as a response to criticism from service users that they can be subject to repeated assessments by different teams and passed between them, resulting in confusion about the course of care, support and treatment they can expect.

3.3 Future Commitments

3.3.1 The 10 Consultation Commitments

Ten specific commitments were given in the Consultation on Improving Mental Health Services in East Sussex, covering improvements and standards for the delivery of community services expected prior to beds closing.

Performance against each of these commitments (referenced to the consultation document in brackets), are set out below:

- **18 Week to treatment target (1)**

The Trust has consistently achieved this target over the last financial year. The overall performance for Quarter 3 (Q3) of 2010/11 was 100%.

- **4 Week to assessment target (1)**

The Trust has consistently achieved this target over the last financial year. The overall performance for Q3 2010/11 was above 95% in all services.

- **4 Hour Urgent response target (7)**

The Trust looks to respond to referrals from GPs in 4 hours where the patient is at risk to themselves or others. In Q3 89 referrals were received in East Sussex, all within the target time.

- **7 Day Access for Long Term Service users (9)**

The Trust saw 99% of these patients within 7 days in Q3 2009/10. This commitment was introduced for the first time in Q3.

- **Care Planning (CPA) Indicators**

Three indicators relate to the Care Programme Approach. Performance against these indicators has recently been assured through a Trust wide audit. The performance figures for East Sussex are as follows:-

Working Age Services Standards	**March 2010 performance**	**October 2010 Performance**
Care plan in place within a week of assessment (2)	95%	100%
Crisis and contingency plan in place (3 and 4)	90%	100%
Care Plan is less than 6 months old (6)	95%	100%

Older peoples services standards	**March 2010 performance**	**October 2010 Performance**
Care plan in place within a week of assessment (2)	90%	100%
Crisis and contingency plan in place (3 and 4)	90%	96%
Care Plan is less than 6 months old (6)	43%	90%

- **7 Day Follow-Up post-hospital Discharge (5)**

Performance in Quarter 3 against this standard for 7 day follow-up post-hospital discharge was achieved in 99% of all cases.

- **Mental Health Helpline (8)**

This help-line has been available across Sussex since last year, and information about the services and the contact number is widely distributed, and is highlighted in

the Trust's web-site. It operates in the evenings (and through the night), and at weekends.

- **Primary Care based Mental Health Professionals (10)**

Qualified Primary Care Mental Health Workers have been allocated to and aligned with every GP practice across East Sussex since April 2010, as part of the Health in Mind Service – see 3.2.5 above.

3.3.2 Service User Engagement and Patient Experience

Service user (and carer) inclusion in all major commissioning / re-design projects has been adopted by commissioners (and more recently the Trust), since adoption by the East Sussex Mental Health Partnership Board at the end of 2009 of a policy setting out this commitment. Examples of this involvement has included full membership on review groups looking at day services (as HOSC may recall from its meeting last autumn), review of counselling services (the conclusions of which have been shared with HOSC), and the CHRT Review, as detailed above.

In addition we continue to secure service user engagement through contracts with local organisations Rethink and Activ8, and on-going membership on the Mental Health Partnership Board and two (locality) Mental Health Actions Groups.

Service user and carer involvement in monitoring the 'Improving Mental Health Services' Programme in East Sussex has been through membership of the 'Stakeholder Reference Group' and production of this Report.

In addition to this involvement in strategic and service developmental processes, the Trust launched a postcard monitoring project in October 2009 which uses feedback postcards to ask service users five simple questions about their satisfaction with services they receive. The postcards are given out at reviews and on discharge from a service.

An independent survey of people who used Sussex Partnership's inpatient services has reported higher satisfaction levels for 2010-11 than previous years. The survey 'Listening to Patients' asked patients about a range of indicators. Scores for people's perceptions of nurses and psychiatrists were up by 10% on the previous year.

The Trust's own regular patient experience monitoring shows an overall satisfaction rate of 91% for the year to December 2010 across all services, against a target of 80%.

3.3.3 Support for Carers and Confidentiality

HOSC identified the vital role played by carers in supporting people with mental health problems, and this was also an issue raised throughout the consultation.

As many of these issues have previously been reported to us, a great deal of work has already been done through processes established and led by the Trust which, for example, convenes a bimonthly Carers' reference group chaired by the Director of Social Care, and includes representatives from all the carers' networks across Sussex. Local authority representatives are also invited and attend regularly.

The group has been taking forward an Action Plan related to the Carers' Charter and this has led to the formation of a number of working groups:

- A group addressing carers' involvement in training
- A group looking at improving performance re: carers' assessments
- A group reviewing our carers' information leaflets as part of the Trust's core leaflet project.

3.4 Conclusions – Community Services

It can hopefully seen and appreciated from the description of community mental health services provided above, as well as from the performance standards being met by them, that a great deal has been achieved in preparing them for providing the necessary care, treatment and support to safely allow the number of in-patient beds to reduce, in line with HOSC and PCT Board supported recommendations.

4.0 Will the proposed in-patient capacity be sufficient to meet future need?

HOSC will be familiar with the work completed by Professor Keith Wilson last year, in which he compared admission rates and lengths of stay for acute in-patient services with what is being achieved elsewhere in the country.

In the context of further review work on the scope and scale of community services available in East Sussex, he also made recommendations as to what would be achievable rates of admission and lengths of stay, and hence the safe number of acute beds that should be made available.

This is summarised below:

Target:	Rates of Admission	Lengths of Stay	Bed Numbers
WAMHS	290 / 100,000	28 days	35.5 ESDW
OPMH (f)	190 / 100,000	50 days	19 ESDW
Sub-total			54.5
WAMHS	290 / 100,000	28 days	24.5 H&R
OPMH (f)	190 / 100,000	50 days	13 H&R
Sub-total			37.5
WAMHS	290 / 100,000	28 days	60 ESX
OPMH (f)	190 / 100,000	50 days	32 ESX
Sub-total			92

(WAMHS = working age adult mental health services, OPMH = older people's mental health, (f) = functional conditions (not dementia), ESDW = East Sussex Downs & Weald, H&R = Hastings & Rother, ESX = East Sussex)

4.1 The Preferred Option for Bed Closures

HOSC will also recall that it supported a preferred option for reconfiguring in-patient services across East Sussex to provide 92 beds which would accommodate both adults and older people suffering with a functional mental illness, allowing for all such wards to be integrated and 'ageless'. The preferred option was:

- Option 2 – Close 20 beds at Bodiam ward at the Department of Psychiatry, Eastbourne DGH, and reduce bed numbers from 33 to 23 at the Woodlands Unit at the Conquest Hospital Hastings: Reduction = 30 beds.

This option was preferred largely due to its performance against the access criteria – in reducing beds in both areas it most closely aligns geographical demand with the location of bed capacity.

4.2 Experience and Learning from Woodlands' Closure

HOSC will be aware that following two serious untoward incidents in 2009, the Woodlands Centre for Acute Care in Hastings temporarily closed due to concerns over safety, and following an extensive programme of refurbishment re-opened with 23 beds (10 fewer than its previous capacity), in the Autumn of 2010

During the period of closure, a number of service developments and improvements were accelerated, including adoption of the functional model of psychiatrist deployment and co-location of CRHT on the site of acute in-patient beds.

These two developments proved to be vital in providing increased and more effective alternatives to hospital admission, and reducing demand whilst locally available bed numbers were reduced. This was one of the ways in which the exceptional circumstances faced were made more manageable.

It can also be seen (in Table under 4.3 below), that despite having re-opened with 10 fewer beds than previously, occupancy levels of East Sussex residents at the Woodlands unit were well under 100% in Quarter 3 of 2010/11.

4.3 Admission Rates and Lengths of Stay – Occupancy Levels

- **Working Age Adult Mental Health Services (WAMHS) Admission Rates**

The target agreed in the consultation was for admission rates to acute psychiatric hospital beds to be managed below 290 per 100,000 of population. The admission rates for East Sussex Downs and Weald (annualised) are 368 per 100,000 weight population, for Hastings and Rother the rate is 300. For East Sussex overall, this translates to an annualised rate of 336 per 100,000.

- **WAMHS Average Length of Stay**

The Trust has invested significant efforts to achieve the reduced length of stay targets in East Sussex. The current length of stay stands at just over 29 days and is on track to achieve the 28 day target in the next quarter. The average length of stay target agreed in the consultation was 28 days for WAMHS acute wards.

- **Older People's Mental Health (OPMH) Admission Rates**

The target agreed in the consultation was for admission rates to acute psychiatric hospital beds to be managed below 190 per 100,000 of population for functional (not dementia) patients. East Sussex Downs and Weald (annualised) admission rates are 132 per 100,000 population and Hastings and Rother are 92. For East Sussex overall, this translates to an annualised rate of 119 per 100,000.

- **OPMH Average Length of stay**

The average length of stay target agreed in the consultation was 50 days for functional. It should be noted that there are two measures of length of stay. The average length of strength of stay considers all patients discharged, where as the

trimmed length of stay excludes the outliers (less than 3 days and greater than 90 days) from the calculation as these may distort the overall picture. The average length of stay for East Sussex Downs and Weald and Hastings and Rother is greater than the target, for both functional and organic patients. However the trimmed length of stay for all areas is within the targets.

- **WAMHS & OPMH – Occupancy Rates**

Extrapolating from Q3 data the annualised number of beds that have been occupied by East Sussex residents, and thereby the number of beds that have not been used, figures in the table below show what progress has been made in reducing demand for beds.

Ward	Beds	Available Bed Days per annum	Q3 Annualised Occupied Bed Days	Q3 Annualised Unoccupied Bed Days	Unoccupied Beds
Amberley	27	9,936	7,648	2,288	6.25
Bodiam	20	7,360	6,168	1,192	3.25
Heathfield	24	8,832	6,016	2,816	7.5
Eastbourne	**71**	**26,128**	**19,832**	**6,296**	**17**
Woodlands	23	8,464	7,064	1,400	3.75
St Raphael	18	6,624	5,040	1,584	4.25
H & R	**41**	**15,088**	**12,104**	**2,984**	**8**
ESX	**112**	**41,216**	**31,936**	**9,280**	**25**

A review of this table clearly suggests that as early as the end of 2010, the numbers of beds in Eastbourne & Hastings that are occupied by East Sussex residents are in line with the numbers of beds to which Professor Wilson in his report had recommended services could safely reduce.

When additionally taking into account that, under Option 2 for bed reconfiguration, all retained beds would operate on an integrated or 'ageless' basis for admissions this picture provides strong early evidence that there may already be scope for reducing bed numbers early in 2011/12.

A number of beds located in East Sussex were being occupied during Q3 by people from Brighton and Hove in particular - this is a temporary phenomenon arising from refurbishment works taking place at Millview Hospital in Hove, which will be completed by mid-June 2011.

4.3 Provisional Programme for Bed Closures

As noted in the Introduction, it is not intended that if HOSC and PCT Boards support in March 2011 a view that community services have indeed demonstrably improved in line with commitments given, and that their impact on admissions rates, lengths of stay and hence bed occupancy safely allows for beds to close, that these closures would all immediately take place in April 2011.

It is planned for example to undertake considerable capital improvement works at the Department of Psychiatry at Eastbourne General Hospital. These will see the day

areas on the ground floor considerably enhanced in their ability to provide therapeutic and recreational activities.

These works will also bring about gender separation by enabling bed reductions to be split between Amberley and a retained Bodiam ward (each providing 17 beds), as well as the re-location of the CRHT next to these wards (where they converge).

The Trust has produced a 'Bed Closure Programme' that shows, given the number of beds at the DoP not currently occupied by East Sussex residents, that once refurbishment works have been completed at Millview Hospital in Hove, and patients move back to their local unit in mid-June, empty beds can be safely 'closed' in Eastbourne by the end of June 2011.

Once refurbishment works commence at the Department of Psychiatry at Eastbourne DGH, that will see much needed improvements made to the therapeutic environment and enable co-location of the CRHT, there will be limited scope for re-opening beds.

However, it can be confirmed that the 10 refurbished but un-staffed / unoccupied beds at Woodlands, would remain available for re-opening should this prove essential during a transitional period of between 3 and 6 months (from April 2011).

Annex A

Statement from service user and carer representative members of the Stakeholder Reference Group

Improving Mental Health Services in East Sussex

Stakeholder Reference Group – Additional Views & Concerns *

Background and Introduction

As has been noted in the Report of the HOSC Task Group dated March 2011 ('Views from Stakeholders'), a Stakeholder Reference Group had been set up to monitor progress and met twice since August 2010 as a management group – consisting of Commissioners and Trust Service Directors.

Once details were made available by the Trust on new models for community services and timescales for their implementation, as well as performance data on commitments given during Consultation, it was agreed to invite service user and carer representatives to meetings (as originally planned), that were convened in early 2011.

As organisations commissioned to engage locally with mental health service users and carers, Rethink and Activ8 nominated representatives to join the group, who are listed below. Separate meetings were also held with Martin Packwood as Joint Commissioning Manager, and Anne Arnold, Sharnie Henley, and Tizzie Coleman, whose additional views and comments on the Progress Report are set out below. **

Overall Conclusions

Although there were concerns that the Progress Report had been produced quickly, and without the levels of engagement with service users and carers that had been originally intended, there was an overall sense that what was proposed did make sense, that a lot had been achieved over recent years, and that given the evident spare capacity available within in-patient units, it appeared safe to go ahead with reducing bed numbers.

Specific Views and Concerns

There was disappointment expressed that if the Trust knew what targets and deadlines there were for developing community services and reducing bed numbers, and knew that service users and stakeholders were to be involved in and consulted on these, why were there delays in producing detailed plans, that effectively prevented this happening.

There was a sense that what had been presented in early 2011 was a 'fait-accomplis' and that its timing had not allowed for Rethink and Activ8 representatives to feed-back to their organisations. This view was important to

air, regardless of whether on balance service users and stakeholders might in fact feel that what was proposed was right, and that beds could safely close.

On this substantive issue however, reference was made to the experience in Hastings where beds had already reduced (at Woodlands), and the whole system still seemed to be working perfectly well. Figures for admissions and bed occupancy at Eastbourne also seemed to be down.

There was an acknowledgement that to some extent the number of beds available was sometimes the number that got used, and having fewer of them could still work if services were robust enough in the community. The problem before had been when the old long-stay hospitals had closed there had been nothing – this was not the case now.

Whilst there was recognition that the CRHTs had to focus more on their key roles of providing alternatives to hospital admission and facilitating early discharge, there was also some concern about what would happen to those who had previously used the CRHT, but would be unable to in the future – who would pick these up?

It was also acknowledged though, that for some people perhaps, some kind of 'medical' response was not of any real use – that people's problems and mental distress were not always the sorts of things that health services could or should help with.

There was some discussion (with reference to the CRHT Review) about the leaflet on 'what to do in a crisis' (which had been circulated in draft form), and the fact that this gave advice about options, but most importantly said not only what could be expected from health services, but also what could not – such as home visits in the middle of the night, except in specific and really very rare circumstances.

Feedback from patient groups was reported as including concerns about CMHTs and AOTs not having noticeably improved, although it was acknowledged that CRHTs had improved and were "doing a better job".

There was a general view that whilst many changes had been right and had resulted in improvements, there was still a lot going on and there was a risk of instability whilst for example CMHTs went through their planned reconfiguration.

Of additional concern were the operational consequences of social work and NHS staff having separate line-management accountabilities, having for example to input data on to different IT systems.

There were other uncertainties about the future, such as what impact direct payments and individual budgets might have on day services, for example if people chose to spend their entitlements on other services.

Returning to the issue of bed reductions, and in particular at Eastbourne, it was reported that the patient council were ‘worried’, but at the same time could also see that services could adapt to there being fewer beds.

Another ‘concern’ though, was whether as a result, people admitted would be more acutely unwell, as was felt to have been seen at Woodlands. Whilst this would probably be the case, with fewer people on the wards it was felt that the experience (from Woodlands), would be that they were better nursed, with potentially higher staff ratios and more personal contact.

Having the CRHT alongside the wards at Eastbourne was also seen as a positive, as was the provision of single sex accommodation and an improved therapeutic environment, resulting from planned refurbishment works. There was also a strong view that Amberly ward was just too big (@ 27 beds) and support for it reducing down to 17 beds.

It was felt overall that in theory, all that was proposed was good, with the principles being agreed that people should be supported and kept well in the community rather than being admitted to hospital.

It was sometimes hard for service users to ‘see’ improvements, for example that there was spare bed capacity in Eastbourne (currently occupied by B&H residents). Nobody was saying there needed to be more beds, and it was understood that in a few months people from Brighton would not be admitted to Eastbourne.

There might be a bit of a panic over changes, because something is being taken away (beds), but also a sense that it will probably “all fall together.”

Services should however remain alert to risks arising from the sheer scale of changes taking place not only in community and in-patient mental health services in East Sussex, but across the NHS in general in terms of re-organisation and staff disruption – there was a real danger of de-stabilisation.

Amongst other concerns expressed was the extent to which training was or would be provided to staff assuming more specialist roles within community teams, including restructured CMHTs. It was not enough to simply designate new teams as ‘specialist’ without ensuring the necessary skills were developed to fulfil such roles.

Although a number of commitments had been given and met in relation to care planning, these did not really measure quality. Care planning and the Care Programme Approach (CPA) was so fundamental to good quality care that there needed to be more evidence available about its effectiveness.

Where carers had queried the quality of individual care planning, it was reported that remedial action had not been taken, suggesting the issue was not always taken seriously by managers responsible for staff performance.

This was of particular concern given that new Recovery & Well-being Teams would provide the focus for CPA practice, and an anxiety that this role may not attract the best qualified staff…hence the need for training.

There was also some more general concern that once approvals for bed reductions had been secured, the Trust would assume that it was 'job-done', and the further developments like training, necessary to ensure community services did continue to improve, would not be a priority.

Whilst not 'against' bed closures, which were to some extent thought to be inevitable, this made the need for transparency and having on-going evidence of continuing improvement all the more important.

There was some acknowledgement that outcome measures were being introduced as part of Trust assessment and care planning processes, and that individuals' improving mental health would become integral to the mechanism for commissioning (and paying for) services, although this would take time to introduce fully.

It was felt that following the Consultation period last Spring, things had suddenly moved very quickly after Christmas, and it was hard as a result to understand all that was being reported and proposed.

Carers wanted assurance that when necessary, there would be access available to a local in-patient bed. What was wanted from the Trust was proper transparency and monitoring of quality.

Notes

* Despite attempts to invite lead GPs to these meetings of the Stakeholder Reference Group, proposals are now being taken for review at a meeting of the Transitional Clinical Executive.

** These additional views and concerns were verified as an accurate representation at the meeting of the Stakeholder Reference Group on 28th February 2011.

Group Membership

East Sussex PCTs

Martin Packwood	Joint Commissioning Manager – Mental Health
Jason Mahoney	Joint Commissioning Manager – Substance Misuse
Nigel Blake-Hussey	Commissioning Manager – Mental Health

East Sussex County Council – Adult Social Care Services

Kate Dawson	Head of Strategic Commissioning - Mental Health

Sussex Partnership Foundation Trust

John Rosser	Service Director – Adult Mental Health Services
Neil Waterhouse	Service Director – Older People's Mental Health Services
Samantha Allen	Service Director – Access

Activ8

Anne Arnold	Service User representative

Rethink

Laura Craven	Service User representative
Peter Noble	Service User representative
Sharnie Henley	Rethink / Service User representative
Tizzie Coleman	Carer representative

East Sussex Health Overview and Scrutiny Committee

Improving mental health services for adults

Progress report

March 2011

East Sussex County Council
eastsussex.gov.uk

Aim of this report

1. In September 2010, HOSC requested that the Task Group it had established to consider proposed changes to mental health services during spring/summer 2010 should reconvene in early 2011 to assess progress. This would be approximately 12 months on from the publication of the proposals. The Task Group comprises Councillors Heaps, Pragnell, Rogers (Chairman) and Tidy.

2. The Task Group met in February 2011 to undertake this assessment of progress and has prepared this report as a summary of its findings.

3. The Task Group's aims were:

- To review progress with the development of community mental health services and
- To assess readiness or otherwise to reduce the number of inpatient beds in line with the decision taken by the Boards of NHS East Sussex Downs and Weald (ESDW) and Hastings and Rother (H&R) in July 2010.

4. In order to achieve these aims the Task Group requested a progress report and performance information from NHS ESDW/H&R and Sussex Partnership NHS Foundation Trust. The Task Group also re-contacted service user/carer representatives and GP representatives who had been involved in HOSC's review during 2010 to request views on progress. An item inviting views was also placed in the December 2010 HOSC newsletter, which has a wide circulation.

5. The Task Group has aimed to weigh up the different evidence and perspectives available to it in order to come to a judgement on the extent of progress in mental health services since March 2010 and what this means in terms of the appropriate balance between inpatient and community based mental health care.

6. This report sets out the Task's Group's findings in terms of:

- How mental health services have changed over the last year or so
- How well the services are doing based on performance information
- Stakeholder views about the services
- Conclusions and recommendation to HOSC.

Progress with mental health services

How have mental health services changed?

7. Over the last year, the Task Group found that there have been a number of developments and changes to mental health services which have followed on from developments over the past several years (reported on in HOSC's original report, July 2010).

8. These developments include:

- **Introduction of the 'functional model'**: This model involves separate teams of consultant psychiatrists working in inpatient units and in the community. Previously, consultants had a caseload based on a geographical area, treating patients whether they were in the community or in hospital. Under the new model, indications are that inpatient specialists are more available to undertake treatment and facilitate discharge, meaning that patients having to spend less time in hospital. This model was introduced in Hastings from August 2010 and in Eastbourne from January 2011.
- **Review of Crisis Resolution Home Treatment (CRHT) service**: This review has resulted in changes to the way these teams work. In Hastings the team has been relocated to the Woodlands inpatient unit, next to the ward, and now works in an integrated 'acute' team with the inpatient staff to fulfil its role in providing an alternative to admission and facilitating early discharge. CRHT in Eastbourne is based within the inpatient building with plans to move onto the ward area and become fully integrated as space becomes available when planned bed closures are implemented.

  The review involved analysis of referrals and resulted in measures to ensure that the teams are used in the best way, as an alternative to admission, by reducing the number of referrals which do not in fact need the team's input. The teams are also extending their service to over 65s with mental health conditions (except dementia) to provide an 'ageless' service and the teams now 'gate-keep' all admissions to inpatient units, or provision of home treatment alternatives.
- **A&E Liaison Service in Eastbourne**: The CRHT review found that Eastbourne's crisis team were being called on to respond to patients attending the A&E department at the hospital. This was diverting time from their primary role. A new, 24/7, A&E liaison service was introduced in January 2011 to address this. A similar service already existed in Hastings.
- **Health in Mind**: This service, introduced from April 2010, incorporates Primary Care Mental Health Workers linked to every GP practice in East Sussex and access to cognitive behavioural therapy through the Improving Access to Psychological Therapies (IAPT) programme. The service is aimed at people experiencing mild to moderate anxiety and depression, aiming to prevent deterioration into more serious problems and to facilitate access to specialist mental health services if required.
- **Mental Health Helpline**: This helpline has been available in East Sussex since January 2010. It operates overnight and at weekends to offer support when mainstream community mental health services are not available

9. The Task Group also found that some further service developments are ongoing, including:

- **Restructuring of Community Mental Health Teams (CMHTs)**: These teams are being restructured into 'Assessment and Treatment' Teams and 'Recovery and Wellbeing' Teams. This move aims to increase specialisation within the teams, clarify roles, reduce duplication for staff and service users and improve care management. Recovery and Wellbeing teams, which will have a particular focus on long-term service users, will operate 7 days a week and into the evenings, providing support for less severe needs thus reducing demand on the CRHT teams. This restructuring is to be completed between April and June 2011.
- **Development of care pathways**: Associated with the restructuring of CMHTs is the development of integrated care pathways for specific conditions (guidelines on how care should be provided). These aim to improve the consistency of care experienced by people and reduce the number of assessments they go through. Some pathways have already been developed but work is ongoing to develop a full range.
- **Further development of Health in Mind**: The IAPT aspect of the Health in Mind service is not yet fully up to speed and it is expected that activity will increase as trainees become qualified practitioners. The service is also planning to develop new interventions for eating disorders and personality disorders and acknowledges that, as still a relatively new service there is further bedding in to do, for example in building relationships and systems with GP practices. These developments will be ongoing over the next 1-2 years
- **'What to do in a crisis**' **– information for service users/carers**: an information leaflet is being designed with service user and carer involvement to provide clearer information on accessing support in a crisis.

10. The Task Group recognises that services continually evolve and there will not be a point when all change is complete. It is clear that significant change has been made over the last year and that some developments are very recent or ongoing.

How well are the services doing?

The '10 Commitments'

11. The Task Group requested performance information against the 10 commitments given in the original NHS consultation document. These commitments set out a range of service standards people could expect from mental health services. The document indicated that when these commitments were being met services would be in a position to support a reduction in inpatient beds.

12. The table below summarises performance against these targets using the available data. Performance data for some commitments has been routinely collected for some time, others required new data collection to be set up and information on their performance has only recently become available. The most recent data for most commitments relates to Quarter 3 (Q3) of the 2010/11 financial year i.e. October – December 2010.

Commitment	***Performance***
1. If you are referred to a community mental health service you will have a single comprehensive assessment from a highly skilled clinician within 4 weeks. If you need treatment you will receive it within a maximum of 18 weeks from the date of your referral.	Q3 2010/11: 4 week to assessment target was **98.6%** in East Sussex Downs & Weald (ESDW) and **99.8%** in Hastings & Rother (H&R). Q3 2010/11: 18 week referral to treatment target was **100%** in both ESDW and H&R

2. If you need treatment you will be provided with a named clinical case manager to work with you to develop a personalised care plan. You will have an agreed care plan within one week of your assessment.	Oct 2010, East Sussex: Care plan in place within a week of assessment in **100%** of cases for working age services and **100%** of cases for older people's services.
3. Your personalised care plan will set out the support that you will receive to help you recover at a pace you feel comfortable with. You should expect to receive the help you need to gain or retain work; to secure accommodation if you don't have any; and you will have access to a direct payment if you want to commission these services yourself.	**See** care planning indicators under commitments **2 and 4** Q3 2010/11: **8.7%** in ESDW and **9.2%** in H&R of people on Care Programme Approach in settled employment, Most recent data on those in settled accommodation for East Sussex (09/10) is **6.7%**. The percentage of (Adult Social Care) mental health services users receiving a direct payment (year-to-date 2010) is **16.1% against a target of 15%**.
4. If you do need treatment you will receive support to help you agree a relapse prevention plan. This will describe how the support that is provided to you will change as your needs change, including a plan for how you will be able to receive more intensive support whenever you need it to prevent a crisis.	Oct 2010, East Sussex: **100%** of working age and **96%** of older people's services clients had a crisis and contingency plan in place.
5. If your needs are high you will have access to a crisis service. If you require an inpatient service you will be admitted to hospital without delay. You will not stay in hospital any longer than you need to and you will be contacted by your clinical case manager within a maximum 7 days after discharge	Q3 2010/11: Follow up within 7 days of discharge achieved in **99%** of cases across the Trust Nov 2010: CRHT 'gate-kept' **100%** of patients before inpatient admission
6. If you are allocated a clinical case manager you will have a review of your needs at least every 6 months and more often if necessary.	Oct 2010, East Sussex: **100%** of working age and **90%** of older people's services clients have care plan less than 6 months old.
7. If you need support in an emergency you should expect to receive an appropriate and effective response within 4 hours.	Q3 2010/11: 4 hour response target to urgent referrals from GPs was met in **100%** of cases in both ESDW and H&R
8. If you need to talk to someone and your clinical case manager is not available you will be able to contact an out of hours helpline which will be available each night and at weekends.	Mental Health Helpline **in place** across East Sussex – operates overnight and at weekends
9. If you have previously been receiving a community service and your GP thinks that you might need support again, you will have a comprehensive assessment within 7 days of your referral.	Q3 2010/11: **99%** of patients re-referred by GPs were seen within 7 days.

10. All GPs in Sussex will have a named mental health professional who will work alongside them in their practice.	Health in Mind **introduced from April 2010** across East Sussex – includes a primary care mental health worker allocated to every GP practice.

13. The Task Group acknowledges that the measures given above are based on performance data and focus mainly on access to services. The experience service users have of the care they receive is much wider than this. However, the measures do give an indication of the accessibility and responsiveness of services and it is important to ensure that the access commitments made have been fulfilled.

Inpatient care

14. The Task Group wanted to see whether the developments outlined above had started to have an impact on use of inpatient mental health units. In particular, whether the number of people admitted had begun to fall, whether the average length of time people stay has been reduced and, related to these factors, whether the pressure on beds had reduced due to lower bed occupancy.

Admissions to inpatient units

15. In terms of admissions to the inpatient units, the Task Group found that the admission rates for working age adults in East Sussex had reduced from 410 per 100,000 of population in 2009 (April-December 2009 annualised* rate) to 336 per 100,000 in 2010 (quarter 3 2010/11 annualised rate). The target for this group is a rate of 290 per 100,000.

16. For older people (excluding dementia) the rate of admission is 119 per 100,000 (quarter 3 2010/11 annualised rate), well below the target of 190 per 100,000.

* this period's admissions extrapolated over a year

Average length of stay in inpatient units

17. The average length of time a patient stays in the inpatient units in East Sussex has also reduced. In 2009 the average length of stay for working age adults was 30 days in ESDW and 40 days in H&R (annualised figure for April-December 2009). The Task Group found that this has now (quarter 3 of 2010/11) reduced to 29 days in both ESDW and H&R, with an expectation that the target of 28 days is likely to be met in quarter 4 of 2010/11. For older people (excluding dementia) the target is 50 days and lengths of stay had reached 48 days in ESDW and 23 days in H&R when 'outliers' are excluded from the calculation (i.e. people who stay less than 3 days or more than 90 days).

Bed occupancy in inpatient units

18. The Task Group reviewed data from quarter three of 2010/11 (October – December 2010) which showed the number of beds in Hastings and Eastbourne occupied by East Sussex residents compared to the number of beds available. This data, when extrapolated to cover a whole year, shows that the equivalent of 17 beds in Eastbourne and 8 beds in Hastings were not being used by East Sussex patients.

19. The units do take a small number of patients who are not East Sussex residents. This number is currently higher than usual in Eastbourne because a ward in Brighton and Hove is being refurbished with Eastbourne providing an alternative during the building works. Around 7-8 beds on average are being used by Brighton & Hove residents and these will no longer be required once the refurbishment is completed by June 2011.

20. It is important to note that the Woodlands Unit in Hastings, which had been closed whilst a review was carried out, re-opened in August 2010 with 10 fewer beds than before its closure. Sussex Partnership NHS Foundation Trust has indicated that this reduction was for safety reasons in line with recommendations arising from the review. This means that, in effect, 10 of the 30 beds identified for closure across East Sussex have already been closed. They remain fully equipped but unstaffed in one part of the unit in the short-medium term, although it is expected that they will be put to another use in the longer term. Evidence suggests that the unit has effectively managed with fewer beds as there has been spare bed capacity as outlined above and it is now rare for a Hastings and Rother patient not to be admitted to Hastings.

Views from stakeholders

21. The Task Group received a limited response to its invitation to stakeholders to submit views. However some helpful responses were received including from Focus on Mental Health (Hastings & Rother), East Sussex Local Involvement Network (LINk), Care for the Carers and specific service user/carer and GP representatives. Some of the responses raised very specific operational issues relating to Health in Mind and the Woodlands Unit. These have been passed on to Sussex Partnership Trust as service feedback.

22. However, the responses did raise a range of issues of direct relevance to the Task Group's progress review. There was some positive feedback on service developments, particularly improvements at the Woodlands Unit and the co-location of the crisis team there. The responses also demonstrate people's feeling that there has been a large amount of change in mental health services and that this is still ongoing, particularly in relation to the restructuring (and in some cases relocation) of the community mental health teams and the 'bedding in' of the Health in Mind service.

23. Some responses suggested that it is too early to be able to fully know the impact of recent changes to mental health services and to judge whether community services are operating effectively. There is a feeling that some of the changes are very recent and it is difficult to judge their effectiveness. In particular, the restructuring of the community mental health teams is felt to be a significant change which is not yet complete. There is also concern that the transitional process may have a negative impact in the short term, whilst recognising it should ultimately be positive.

24. Responses also expressed some concern over the level of service user involvement in monitoring progress. It was recognised that Sussex Partnership Trust has established 'Making it Happen' groups with service user involvement which are designed to oversee implementation of the Trust's strategy for services. A stakeholder reference group established to monitor progress had been meeting as a management group until February 2011 when it had been extended to include service user and carer representatives. It was suggested by the lead commissioner that all the necessary data to monitor progress had not been available until this time.

25. One response expressed concern that the measures being used to monitor progress were too weighted towards 'process' measures such as access times and not enough towards seeking service user views. The Task Group noted that there was now a clear expectation in the contract agreement between NHS ESDW/H&R and Sussex Partnership Trust for feedback to be collected from service users and carers about their experiences and that this will be reported on in future.

26. The Task Group hears and understands these concerns. There has clearly been much change in recent months and years and more to come. Whilst efforts are being made to involve and communicate with service user and carer representatives, the Task Group believes that these efforts need to be reinforced over the coming months.

Conclusions and recommendations

27. The Task Group has reviewed a considerable amount of evidence in order to assess the progress of mental health services. Overall, the impression is of significant progress made, with more to do. The restructuring of community mental health teams in particular is a significant further step to be completed over the next few months. No doubt the new structure will take some time to become established and will take time for staff and service users to adapt to.

28. It is recognised that services will continually be evolving and developing. There will not be a time when all change is complete. The key question for HOSC to consider is whether *sufficient* progress has been made to enable a further rebalancing of services towards community based support and away from inpatient care.

29. Concerns have been raised about aspects of community services which must be set against other evidence of improved performance. It is important to consider whether continuing with the same level of inpatient bed capacity in the county will help address concerns raised.

30. Sussex Partnership Trust has put forward a proposed programme for closure of the remaining 20 beds, of the 30 it was agreed would close under the preferred option selected by the Boards of NHS ESDW/H&R in July 2010. 10 beds have already closed in Hastings, leaving a reduction of 20 beds in Eastbourne still to be implemented. The proposal is for the closure of these 20 beds by June 2011.

31. The closure of the beds would enable improvements to be made at the Eastbourne unit, particularly creating the space to relocate the crisis team next to the ward area, enabling them to work with the inpatient staff in the fully integrated model which is working successfully in Hastings. The space created would also enable improvements to be made to the physical environment in the unit, including improved gender separation.

32. The Task Group's view, on balance, is that sufficient progress is demonstrated by the evidence to enable the reduction in beds in line with the proposed timetable. It is important to take into account the spare capacity currently available in the units and the scope for further improvement given recent service developments and the opportunity to fully establish an integrated acute team in Eastbourne.

33. The improvements being instigated as a result of the review of Crisis Resolution Home Treatment services are significant in offering reassurance that alternatives to admission are available and that the teams are now able to be more responsive to urgent needs.

34. This view does not mean that there is no need for further improvement of community services. The Task Group has heard the concerns raised and understands the need for further work, for example on the development of integrated care pathways, support for carers and work with GPs. However, the Task Group is not convinced that keeping beds open will have a significant benefit in this regard.

35. Given the ongoing change in mental health services and the concerns raised by some stakeholders, the Task Group believes that HOSC should continue to monitor progress closely and ensure that recent improvements are sustained and developed. Our recommendations below reflect this, and include further safeguards we believe are important in assuring local people that bed reductions are being undertaken in a careful, timely way.

Recommendations

Recommendation 1

HOSC should support the proposed bed closures by June 2011 subject to the following caveats:

a) That Quarter 4 2010/11 data, when it is available in early April, should demonstrate a sustained or improved level of performance from Quarter 3 (the most recent data available to the Task Group).

b) That the refurbishment of the inpatient ward in Brighton & Hove should be completed prior to the bed closures at Eastbourne.

c) That the 10 closed beds in Hastings should remain available (i.e. not used for something else) as a backstop for a transitional period of 6 months from April 2011 in case unforeseen significant additional demand for inpatient care arises within East Sussex and necessitates reopening of beds.

d) That HOSC receives a communications and involvement plan setting out activity which will be undertaken prior to and during the bed closure programme to inform and involve service users, carers and stakeholders in East Sussex of developments in mental health services (both community and inpatient changes).

Recommendation 2

HOSC should continue to monitor progress with adult mental health services closely, including:

a) A further meeting of the Task Group in April 2011 to review quarter 4 2010/11 performance data.

b) A progress report to HOSC in September 2011.

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