PROJECT TO SHIFT ACUTE MENTAL HEALTH CARE PROVISION FROM HOSPITAL TO COMMUNITY IN SOUTH STAFFORDSHIRE

EXECUTIVE SUMMARY

This paper describes proposals to increase the level of provision of acute mental health care in community settings and reduce the reliance on inpatient care in a planned and monitored fashion. This development is based on local and national policy and aims to provide care in the least restrictive environment possible. National research demonstrates that the provision of teams to provide people with intensive treatment in their own homes can significantly reduce the need for inpatient beds and improve service user experience.

This paper describes the process, time scale and quality measures proposed to be used during a six month phased development across South Staffordshire.

Local Service Developments in South Staffordshire

This year has seen significant new investment by the PCT in the two Crisis Resolution and Home Treatment Teams (CRHTTs) in South Staffordshire, to a level indicated by national guidance. This will enable CRHTTs to provide intensive home care/treatment to the patient in his/her own home as an alternative to admission, to support timely discharge for those admitted to hospital, and provide a rapid face-to-face assessment service for people with acute mental health needs who appear to pose an immediate risk and potentially require hospitalisation. The CRHTTs will gate keep all admissions by assessing all patients being considered for admission to acute admission wards (including older people with functional conditions). Where home treatment is clinically viable and desirable, this will consist of visits of up to several times per day with additional phone calls per day and access to a range of interventions including ongoing risk assessment, carer support, medication, supportive counselling and focused problem solving. The service will be available for 24 hours per day, 365 days a year. The Trust is also introducing a ‘Functional’ model of care whereby consultant psychiatrists will specialise in either inpatient, crisis or community work to improve team working and consistency and make decision making more timely.

Proposed service changes

- A gradual, reversible reduction of inpatient beds across South Staffordshire at the rate of two per month and totalling 12 beds;
- A defined baseline of community based services to be in place before each bed reduction;
- A structured review of quality data as changes are implemented, including service user feedback, review of complaints and compliments, untoward incidents and an audit of Crisis Resolution and Home Treatment communications.

Joint Review

It has now agreed that the project is supported and monitored by PBC leads over a six month period to ensure a robust and safe approach to acute community care provision and to ascertain the viability of further future bed closures.
1. Introduction and Overview

1.1 This document provides an overview of the background to the development of local alternatives to hospital admission, and proposes a phased process of reversible bed reduction matched against an increasing level of acute adult and older adult community based mental health provision.

The phased roll-out of bed reduction will be reviewed regularly against a number of quality and safety indicators and it is proposed that the project is supported, monitored and critiqued by PBC leads over a six month period to ensure a robust and safe approach to acute community care provision and to ascertain the viability of further permanent future bed closures.

National developments and research

1.2 In the UK, from the 1990s, the Community Mental Health Teams were the main providers of emergency interventions in the community. However in the late 1990s there was pressure for a new approach to the management of psychiatric emergencies. This was due to:

- A small increase in the acute admission rate for adults and a larger rise in formal admissions (Szmukler and Holloway, 2001)
- Service user, carer, GP dissatisfaction with the response to emergencies especially out of hours
- Service user experiences of admission to acute admissions wards was poor – many feeling unsafe especially from other patients (Rose, 2001) and wards were criticised for the lack of therapeutic interventions with the service users (Quirk and Lettiott, 2001)

The above led to the introduction of NHS modernisation plans that were introduced between 1999 & 2002. Later plans such as The NHS Plan (Department of Health, 2000) set a target of 335 crisis teams nationally which would each see an average of 300 patients a year, carrying a case load of 20 to 30 patients at a time (Department of Health, 2001) and be available 24 hours a day, seven days a week.

Historically, the provision of teams to provide people with treatment within their own environments has reduced the need for in patient beds and has increased the efficacy of treatments. This has been true in a number of pioneering countries such as Australia (Reynolds et al (1990) & Hoult, 1991) and the USA (Stein, 1991) where such services helped to provide the care needed in less restrictive environments.

In the United States of America in the 1980s & 1990s there was the concept of mobile crisis services but these were really an ad hoc response to local service needs and were nothing more than triage services. (Allen, 1996)

The introduction of crisis resolution/home treatment teams in England has been associated with a reduction in hospital admissions. Between 2001 and 2004 there was a rapid expansion in the numbers of these teams.
Trials were established to examine whether national implementation of these teams was associated with comparable reductions in acute admissions to hospital.

Glover and Associates (2006) conducted an observational study using routine data covering working age adult patients in 229 of the 303 local health areas in England from 1998/9 to 2003/4 was carried out.

Scrutiny of the results showed that admissions fell generally throughout the period, particularly for younger working age adults. Introduction of crisis resolution teams was associated with greater reductions for older working age women (35–64 years); teams 'always on call' were associated with additional reductions for older men and younger women. By the end of the study admissions had fallen by 10% more in the 34 areas with crisis resolution teams in place since 2001, and by 23% more in the 12 of these on call around the clock than in the 130 areas without such teams by 2003/4. Reductions in bed use were smaller. Introduction of assertive outreach teams was not associated with overall reductions in admissions.

The final conclusions from the study indicated that the Introduction of crisis resolution teams has been associated with reductions in acute hospital admissions.

Johnson and colleagues (2005a, b), working in North London, have reported a before-and-after and a randomised controlled trial of a crisis resolution team. Both indicated a substantial reduction in admissions.

**Alternatives to admission locally**

1.3 Two Crisis Resolution and Home Treatment Teams (CRHTTs) currently exist in South Staffordshire. Although the financial resource available for these teams was less than indicated by national guidance and they also carry the additional role of out of hours cover for Accident and Emergency Departments, they have made a measurable difference to patients’ care, particularly in allowing for more speedy response to emergency referrals. Recently commissioning via the LDP process in 2009 elicited significant new investment by the PCT, for the home treatment function of the CRHTTs, which will support the next step which is to provide full and needs-led intensive care and treatment to the patient in their own homes as an alternative to psychiatric hospital admission and to also support timely discharge from hospital as well as to provide a rapid, face-to-face holistic assessment service.

In order to support a shift to intensive care and treatment at home rather than in hospital wherever this is clinically viable, the CRHTTs will gate keep all potential admissions to psychiatric beds by assessing all patients - including those over the age of 65 years who present with a functional disorder – referred to the service via the CMHT’s Single Point of Access (SPA) or directly to CRHTT out of hours - who are considered as potentially requiring admission to hospital.

All individuals who would benefit from intensive care and treatment at home as an alternative to psychiatric hospital treatment will be assessed by a team of multi disciplinary professionals in order to initiate a programme of home treatment with frequent visits (typically multiple daily visits, but at least daily in the acute phase).

Home treatment will continue until either the acute phase of the condition has passed and the risks reduced and the crisis resolved and the patient’s needs are able to be met by less intensive input or hospital admission is recommended.
Intensive care and treatment at home will typically not exceed 6 weeks and, in some cases, the duration required will be a few days as opposed to weeks; however, each individual case will be reviewed daily and clinical decisions based on robust ongoing assessment.

1.4.1 In addition to the expansion of Crisis Home Treatment Services a structural change in the organisation and delivery of mental health care will be instigated, known as ‘Functionalisation’. This approach is characterised by

- Consultant psychiatrists specialising in, either, inpatient, crisis or community roles. Increasing specific expertise, reducing variation in approach by service area and strengthening team working through consistent membership
- An approach to the provision of inpatient care that removes traditional approaches that are neither service user centred or efficient, for example major decision making taking place at a ward round once per week rather than being more responsive to service users’ need through daily reviews.

The Trust has had extensive contact with other organisations utilising this model, particularly in the Tees, Esk and Wear, and has learned from their successes and challenges in making this model effective.

1.5 Where a hospital admission is recommended by CRHTTs, they will facilitate a timely process and will complete a ‘Purpose of Admission Form’ to assist in the formulation of treatment goals. This will explain why the service user has been admitted, what the purpose is of the admission and identify what needs to change in order for the patient to be discharged into the care of the CRHTT and thereby treated at home. Details will also include the rationale for why the patient cannot be managed appropriately by the CMHTs or other community resources due to the level of risk and the intensive nature of the care and treatment required. Admission to hospital or admission to Home treatment may not always follow a period of crisis but may be a planned episode.

The following list is the factors that are particularly clinically significant for consideration when considering a possible hospital admission or episode of home treatment:

- Level of risk – to self or others
- Support mechanisms and networks currently in place for the individual
- Psychiatric history
- Social stressors
- Service user compliance to recommended treatment
- Service user engagement
- Capacity of Home Treatment Team
- Home Treatment Team skill sets

Following an admission to hospital, the CRHTT will remain in very regular contact with the service user and will be part of the multi-disciplinary team that assesses for timely discharge. It is recognised that it is vital to continually review the treatment and the service users’ progress during the in-patient stay as this supports the decision making when considering timely discharge.

Hospital discharge planning has a focus on ensuring:
A multi disciplinary approach
• Full service user involvement and engagement
• Comprehensive care planning and risk assessment including feedback on observation and intervention and any trial periods of leave from hospital
• Involvement of carers where appropriate
• Ongoing care and treatment and planning for future relapse. The transfer between CRHTT and other community/functional teams will be described in a transition pathway/protocol/policy and the relapse plan will be managed within the community.

At the appropriate time, and according to the agreed care plan, the individual will then be discharged into the care of the team for at least 72 hours post discharge (and where necessary up to 6 weeks) and the 48 hour follow up visit will be carried out by CRHTT.

People referred to CRHTT, but not needing admission or intensive home treatment

People who do not need intensive input will be signposted to the most appropriate service for their needs. CRHTT will ensure that suitable follow up is in place where input is required from other, less intensive, mental health services.

2. The Proposal

2.1 Phased Bed Reduction Matched Against Community Resource

Appendix B outlines the proposed plan to reduce beds across South Staffordshire to reflect the increase in Home Treatment as an alternative to psychiatric ward admission. The plan involves four wards and over the 6 month period, commencing 1st October 2010, will demonstrate the success of bed closures based on sound community resource and through the monitoring of key quality indicators.

The plan, phased over the 6 month period, proposes a total of 12 reversible bed closures:

• MSC Adult Admission Ward (Burton) – 5 closed beds
• Brocton Adult Admission Ward (Stafford) – 4 closed beds
• Bromley Older People Admission Ward (Stafford) – 1 closed bed
• MSC Older People Admission Ward (Burton) – 2 closed beds

This phasing takes into consideration the development of the service in relation to the enhancement of Home Treatment and also the need to safely build capacity for meaningful Home Treatment for older people presenting with functional disorders. However, without key aspects of the planned service e.g. Acute Day Services and additional resource from proposed disinvestments for specialised older people input, the full plan for Home Treatment cannot be delivered. This is reflected in the detailed plan at Appendix B in the community resource column.

2.2 Quality and Safety Measures
There are a number of factors that will be taken into consideration when the quality and safety of care is reviewed, both at an individual patient level and, more broadly, at service level...

Individual
- Decreased level of risk or enhanced management of existing risk
- Compliance with the treatment plan
- Supportive and enabling social network
- Understanding of presenting psychiatric condition
- Relapse/Crisis planning through CPA

Service
- Patient satisfaction survey (based on SHA mandated CQUIN requirements. Appendix A)
- Carer satisfaction survey
- Peer review of health records against a predefined matrix of standards
- Audit of adherence to pathways and quality of assessment and communications
- Attendance of staff at supervision and relevant professional development
- Phone satisfaction surveys of a sample of GPs who have referred to CRHTs each month
- Complaints, compliments and incident data

Some of these will be internal measures, but as many as possible will form a part of the quality and safety management as described in the table at Appendix B.

2.3 Monitoring Process

The proposed plan will need careful and accurate monitoring and evaluation at the end of the project. It is envisaged that on a monthly basis prior, to the next proposed bed closure, a report will be produced identifying compliance with the planned community resource and qualifying parameters e.g. no out of area patients (those patients placed outside of the PCT catchment area). This report will be shared with internal stakeholders and commissioners. If the compliance falls short of the expectation then the planned bed closure will need to be reviewed.

Similarly, after the first month of the plan, a quality and safety report will be produced and shared with stakeholders and any concerns over quality, safety or service user/carer experience will be addressed before further bed closures are made.

The Trust has agreed to meet formally with PBC leads to monitor the plan after 3 months, and at the end of the six months a final report will be produced to fairly reflect the success or otherwise of the project. Should PBC representatives have any concern about the progression of the plan at any time then a review meeting can be called to consider the issue and need for any action.

2.4 Future Action

This proposal has been reviewed, amended as appropriate and agreed with PBC leads prior to implementation and has also been shared with internal SSSFT stakeholders for comments and to ensure all aspects of the project will be delivered as per plan. Comments on the process have also been sought from the SSSFT Service User and Carer group.
Detailed protocols will be issued to CRHTTs and to the wards to ensure that service users continue to receive effective acute care, and to ensure staff are clear about the nature of the project.

Terms of reference and data capture protocols will be developed for the monthly reports to ensure effective monitoring.

A communication plan is being drafted to reflect the improved service and confirm the acute care pathway for the benefit of service users and carers and referrers to the service, particularly GPs.

A formal post project evaluation will need to be conducted to be clear on the success of the project and to identify any lessons to be learned or qualitative and quantitative data required to inform decisions about future bed closures.

3. Conclusion

The enhancement of the Home Treatment function of the CRHTTs in South Staffordshire will ensure that, wherever possible and whenever clinical need dictates, service users in acute need are treated in their own home/environment as opposed to admitting to psychiatric hospital.

Only those service users with the most appropriate needs for inpatient care will be admitted to an Acute Admission Ward and wherever possible for the least length of time. They will then receive support in their transition to their home environment.

From 1st October 2010, the 6 month phased process of bed closures will commence following the agreement of PCT and PBC leads on 30th September.

References


We would like to know your experience of our services so that we can provide more of what we do well and improve what is not working so well.

**Which Team / service is this survey being completed about?**

Do you think your views were taken into account when deciding what was in your care plan?

- [✓] Yes
- [ ] No

How could this be improved?
Were you given enough time to discuss your condition with healthcare professionals?

✓  

Yes □  No □

How could this be improved?

Were both the purpose and the side effects of medications explained to you?

✓  

Yes □  No □

How could this be improved?
Do you have a number of someone from your local NHS Mental Health Service that you can phone out of office hours?

✓

Yes □

No □

How could this be improved?

Have you been given (or offered) a written or printed copy of your care plan?

✓

Yes □

No □

How could this be improved?
How would you rate the service you received?

- Excellent □
- Not Good □
- Good □
- Poor □
- OK □

Is there anything about the service that particularly pleased you?

- Yes □
- No □

Please add comments if you wish
Is there anything about the service that you feel needs to change?

- [✓] Yes  
- [ ] No

Please add comments if you wish

Do you know what to do if you are not pleased with the service you received?

- [✓] Yes  
- [ ] No

Please add comments if you wish
Your name is not kept on this survey. However, it does help to know a bit about your background. Please help us learn how to help you better by answering these final questions.

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<th>How old are you?</th>
<th>What is your ethnic group?</th>
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<td>Indian</td>
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<td>Other Asian</td>
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<td>Any Other Group</td>
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<th>Are you male or female?</th>
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<tr>
<td>Male</td>
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<td>Female</td>
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Thank You!
APPENDIX B

Timetable and Monitoring Criteria for Increased Acute Community Based Provision and Related Bed Reduction

The following table provides an estimated trajectory for bed reductions linked to the availability of specific community resources and activity and with quality and safety criteria identified to be reviewed at each stage. Should the planned resource/activity not be in place at the planned time or the quality criteria contra indicates any further reduction at time of review then this would only take place when these indications were in place.

<table>
<thead>
<tr>
<th>Estimated Bed Reduction</th>
<th>Community Resource</th>
<th>Review Quality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.10.10</td>
<td>1 bed MSC adult 1 bed St George’s adult</td>
<td>• 70% planned staffing in CRHTTs</td>
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<td>1.10.10</td>
<td></td>
<td>• 45% of all working age admissions assessed face-to-face by core CRHTT staff</td>
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<td></td>
<td></td>
<td>• No Staffordshire patients in out of area acute beds</td>
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<tr>
<td>1.11.10</td>
<td>1 bed MSC adult 1 bed St George’s adult</td>
<td>• 75% planned staffing in CRHTTs</td>
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<td>• 55% of all admissions assessed face-to-face by core CRHTT staff</td>
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<td>• No Staffordshire patients in out of area acute beds</td>
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<td></td>
<td></td>
<td>• Evidence of delivery of home treatment episodes equivalent to 60 OBDs</td>
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<td></td>
<td></td>
<td>• Service user feedback survey results October</td>
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<td></td>
<td></td>
<td>• Trial of carer questionnaire complete</td>
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<td></td>
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<td>• GP phone feedback questionnaire October</td>
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<td></td>
<td>• Evidence of complaints and compliments in acute pathway</td>
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<td></td>
<td></td>
<td>• Incidents and serious untoward incident review</td>
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<td></td>
<td></td>
<td>• Review of out of area placements</td>
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<td></td>
<td></td>
<td>• Complete matrix for notes review</td>
</tr>
<tr>
<td>Estimated Bed Reduction</td>
<td>Community Resource</td>
<td>Review Quality Data</td>
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</table>
| 1.12.10 1 bed MSC acute 1 bed St George’s acute | • 80% planned staffing in CRHTTs  
• 65% of working age admissions assessed face-to-face by core CRHTT staff  
• No Staffordshire patients in out of area acute beds  
• Evidence of delivery of home treatment episodes equivalent to 120 OBDs | • Service user feedback survey results November  
• Carer questionnaire results November  
• GP phone feedback questionnaire  
• Evidence of complaints and compliments in acute pathway  
• Incidents and serious untoward incident review  
• Audit of CRHTT communications, e.g. quality of assessment letters  
• Peer notes review November |
| 1.01.11 1 bed MSC acute 1 bed St George’s Older adult | • 95% planned staffing in CRHTTs  
• 75% of all admissions assessed face-to-face by core CRHTT staff  
• No Staffordshire patients in out of area acute beds  
• Evidence of delivery of home treatment episodes equivalent to 180 OBDs  
• Significant home treatment service for Older People with functional illnesses | • Service user feedback survey results December  
• Carer questionnaire results December  
• GP phone feedback questionnaire  
• Evidence of complaints and compliments in acute pathway  
• Incidents and serious untoward incident review  
• Audit of CRHTT communications, e.g. quality of assessment letters  
• Peer notes review December |
| 1.02.11 1 bed St George’s acute 1 bed MSC older adult | • 95% planned staffing in CRHTT's  
• 85% of all admissions assessed face-to-face by core CRHTT staff  
• No Staffordshire patients in out of area acute beds  
• Evidence of delivery of home treatment episodes equivalent to 240 OBDs  
• Completion of staff training in working with older people | • Service user feedback survey results January  
• Carer questionnaire results January  
• GP phone feedback questionnaire  
• Evidence of complaints and compliments in acute pathway  
• Incidents and serious untoward incident review  
• Review of out of area placements  
• Review of level of detention under the MHA  
• Review of level of face to face CRHTT assessment and gatekeeping of admissions to hospital  
• Audit of CRHTT communications, e.g. quality of assessment letters  
• Peer notes review January |
<table>
<thead>
<tr>
<th>Estimated Bed Reduction</th>
<th>Community Resource</th>
<th>Review Quality Data</th>
</tr>
</thead>
</table>
| 1.03.11 1 bed MSC acute 1 bed MSC older adult | • 95% planned staffing in CRHTTs  
• 95% of all admissions assessed face-to-face by core CRHTT staff  
• Evidence of delivery of home treatment episodes equivalent to 300 OBDs  
• No South Staffordshire patients in out of area acute beds  
• Significant home treatment service for Older People with functional illnesses | • Service user feedback survey results February  
• Carer questionnaire results February  
• GP phone feedback questionnaire  
• Evidence of complaints and compliments in acute pathway  
• Incidents and serious untoward incident review  
• Audit of CRHTT communications, e.g. quality of assessment letters  
• Peer notes review February |